103

HEALTH INSURANCE INDUSTRY PRACTICES

Y 4. EN 2/3: 103-151

Health Insurance Industry Practices...

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

JUNE 29 and AUGUST 3, 1994

Serial No. 103–151

Printed for the use of the Committee on Energy and Commerce

APR 5 1995

HEALTH INSURANCE INDUSTRY PRACTICES

HEARINGS

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON
ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRD CONGRESS

SECOND SESSION

JUNE 29 and AUGUST 3, 1994

Serial No. 103–151

Printed for the use of the Committee on Energy and Commerce

U.S. GOVERNMENT PRINTING OFFICE

86-339CC WASHINGTON : 1995

For sale by the U.S. Government Printing Office
Superintendent of Documents, Congressional Sales Office, Washington, DC 20402
ISBN 0-16-046673-3

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

HENRY A. WAXMAN, California
PHILIP R. SHARP, Indiana
EDWARD J. MARKEY, Massachusetts
AL SWIFT, Washington
CARDISS COLLINS, Illinois
MIKE SYNAR, Oklahoma
W.J. "BILLY" TAUZIN, Louisiana
RON WYDEN, Oregon
RALPH M. HALL, Texas
BILL RICHARDSON, New Mexico
JIM SLATTERY, Kansas
JOHN BRYANT, Texas
RICK BOUCHER, Virginia
JIM COOPER, Tennessee
J. ROY ROWLAND, Georgia
THOMAS J. MANTON, New York
EDOLPHUS TOWNS, New York
GERRY E. STUDDS, Massachusetts
RICHARD H. LEHMAN, California
FRANK PALLONE, Jr., New Jersey
CRAIG A. WASHINGTON, Texas
LYNN SCHENK, California
SHERROD BROWN, Ohio
MIKE KREIDLER, Washington
MARJORIE MARGOLIES-MEZVINSKY, Pennsylvania
BLANCHE M. LAMBERT, Arkansas

CARLOS J. MOORHEAD, California
THOMAS J. BLILEY, Jr., Virginia
JACK FIELDS, Texas
MICHAEL G. OXLEY, Ohio
MICHAEL BILIRAKIS, Florida
DAN SCHAEFER, Colorado
JOE BARTON, Texas
ALEX McMILLAN, North Carolina
J. DENNIS HASTERT, Illinois
FRED UPTON, Michigan
CLIFF STEARNS, Florida
BILL PAXON, New York
PAUL E. GILLMOR, Ohio
SCOTT KLUG, Wisconsin
GARY A. FRANKS, Connecticut
JAMES C. GREENWOOD, Pennsylvania
MICHAEL D. CRAPO, Idaho

Alan J. Roth, *Staff Director and Chief Counsel*
Dennis B. Fitzgibbons, *Deputy Staff Director*
Margaret A. Durbin, *Minority Chief Counsel and Staff Director*

Subcommittee on Oversight and Investigations

JOHN D. DINGELL, Michigan, *Chairman*

SHERROD BROWN, Ohio
MARJORIE MARGOLIES-MEZVINSKY, Pennsylvania
HENRY A. WAXMAN, California
CARDISS COLLINS, Illinois
RON WYDEN, Oregon
JOHN BRYANT, Texas

DAN SCHAEFER, Colorado
CARLOS J. MOORHEAD, California
JOE BARTON, Texas
FRED UPTON, Michigan

Reid P.F. Stuntz, *Staff Director/Chief Counsel*
D.Ann Murphy, *Special Assistant*
Christopher Knauer, *Special Assistant*
Dennis B. Wilson, *Minority Counsel*

CONTENTS

Page

Hearings held on:
- June 29, 1994 ... 1
- August 3, 1994 ... 363

Testimony of:
- Coffman, Mike, Colorado State Representative ... 417
- Curiale, Salvatore R., Superintendent of Insurance, State of New York ... 123
- Foley, Thomas C., Actuary, Florida Department of Insurance ... 101
- Groenke, Kathryn Kristine, Crofton, MD ... 233
- Hough, Stephen J., Croegaert, Clark & Hough, Ltd ... 233
- Hurwit, Cathy, Legislative Director, Citizen Action ... 365
- Scorsone, Ernesto, Kentucky State Representative ... 385
- Shaheen, C. Jeanne, New Hampshire State Senator ... 137
- Van Cooper, Thomas R., Director, Insurance Regulation, Department of Banking, Insurance, and Securities, State of Vermont ... 40
- Whelan, John M., CEO, Golden Rule Insurance Company ... 440
- Winegarden, Daniel Potts, First Deputy Insurance Commissioner, State of Iowa ... 387

Material submitted for the record by:
- Moorehead, Hon. Carlos J., prepared statement of ... 362

HEALTH INSURANCE INDUSTRY PRACTICES

WEDNESDAY, JUNE 29, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. John D. Dingell (chairman) presiding.

Mr. DINGELL. The subcommittee will come to order.

Today the subcommittee will hold the first in an interesting series of hearings into the health insurance industry. During the course of this inquiry, the subcommittee will examine what role the multi-billion dollar industry plays in runaway health care costs, in access to health care, and in the quality of that care. This review is going to be thorough, and it is going to be exhaustive, and it will include the financial practices throughout the industry, who the players are, and how they, and their organizational structures and interrelationships are changing.

The subcommittee will assess these matters in depth, and we intend to determine why the existing regulatory systems have let the insurance company bureaucrats have life or death power over too many ordinary citizens. Health care is too important to leave in the hands of powerful and unaccountable insurance companies.

These companies are constrained only by a patchwork of regulatory policies that rest largely in the States and that differ dramatically from State to State and from company to company. This subcommittee knows only too well from its ongoing investigation into insurance company insolvencies that those regulations often are riddled with loopholes and their implementation is too often spotty and lackluster. The subcommittee knows, moreover, that many State regulators wage a daily uphill battle against powerful insurance lobbies that have attempted to strangle all State reform efforts.

Today's hearing will focus on the activities of what many believe is the largest insurer offering individual health insurance policies. That company is Golden Rule Insurance Company—a nice name—headquartered in Lawrenceville, Illinois, and Indianapolis, Indiana. The company has been a controversial player and a controversial figure in a number of States, and depending upon who you talk to, is either a staunch advocate for consumers and political activism or a greedy predator feasting on a captive population.

According to some State regulators, some of whom we will hear from today, Golden Rule routinely engages in intimidation, misin-

formation and other underhanded practices to secure huge rate increases and preferential policies as well as to thwart health insurance reform. Still others have accused Golden Rule of being a "bait-and-switch insurance company" and "rip-off artists."

Golden Rule representatives when confronted with their lobbying practices, their telemarketing campaigns, and what many believe are smear tactics, suggest that they are merely being "politically aggressive." That "aggressiveness" has prompted Golden Rule to sue many insurance commissioners, charging they "would do it to us if it could be done without public scrutiny," or that the insurance department practices are "analogous to police abuse," and it has also prompted Golden Rule to sue a number of its policyholders rather than to pay for medical benefits those consumers thought their rather hefty premiums made them entitled to.

Today we will hear from legislators and regulators from four different States, and we will hear from consumers and their representatives. Golden Rule representatives will be called upon to testify at a later date, once that company has complied fully with the committee's 3-month old document request and provided other needed information. They will address these important issues and respond to these specific allegations at that time.

We are pleased to hear what our witnesses and panels have to say, and we look forward to your testimony.

The Chair wants to express the gratitude of the committee to our first panel for your presence today, your assistance to us in this matter, and we will look forward to your testimony.

The Chair is going to recognize the distinguished gentleman from Colorado, Mr. Schaefer, for such opening statement as he chooses.

Mr. SCHAEFER. Well, thank you, Mr. Chairman. Today's hearing continues the subcommittee's examination of the various financial practices in the health care industry and begins what I understand will be a series of hearings focusing on health insurance.

The topic of insurance is a familiar one to all of us on this subcommittee. Our long-running investigation of insurer solvency has showed the devastating effects a company's insolvency has on its policyholders. The issues we are now beginning to examine in the health insurance area may have equally devastating and far-reaching consequences.

Two practices we will focus on today are particularly troublesome: cherrypicking and post-claims underwriting. "Cherrypicking" refers to the practice of insuring only the best risks, in this case, the youngest and the healthiest, while leaving the older sicker people underinsured or not insured or forcing them into quasi-governmental plans that are required to take all comers at high premium costs. Of course, the line between good underwriting and cherrypicking may not always be clear. I hope we will get some clarification on this matter today.

"Post-claims underwriting" refers to a practice whereby the insurer looks for ways to deny a claim after it is made with the goal of rooting out fraud or misrepresentation by the insured. Again, there are undoubtedly a number of cases where this practice is entirely proper, but I understand we will hear today about instances where the company's actions may have crossed the line.

Mr. Chairman, I look forward to this testimony. I appreciate the fact that the subcommittee's work has dug up information on this particular situation, and look forward to ways that we can improve on it.

I yield back my time.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair recognizes the gentleman from Oregon, Mr. Wyden.

Mr. WYDEN. Thank you very much, Mr. Chairman, and I am very pleased that you are launching this inquiry and particularly that you have committed to an in-depth analysis of these kinds of insurance practices.

In my view, too many insurance companies are trying to perpetuate business as usual, while wearing the friendly face of reform in the media and on television. Today we are going to have a chance to hear from insurance commissioners and experts about insurance practices in a company. When they couldn't win by persuasion, this company sought to win by intimidation; intimidation of consumers, their attorneys, and lawmakers.

I think, Mr. Chairman, that our colleagues know that this committee is not easily intimidated. The Chairman has led us in particular into efforts to examine the Medigap market that led to this committee's Medigap reform legislation that in effect drained that swamp that spawned and sustained health insurers that preyed on senior citizens.

I would like to note that a number of companies pulled out of the Medigap market in my State shortly after that reform was implemented. They don't seem to have been especially missed, and I suspect that when you turn the spotlight on other companies in this inquiry that are engaging in these kind of ripoff practices that fleece the consumers of this country, that some of the other States will experience what we did in Oregon and see some of these companies slink out of the marketplace. So I am very pleased that you are going forward with this inquiry and look forward to participating.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair, without objection, will insert into the record at this point a number of communications, a communication of Mr. John Whelan, Chief Executive Officer, Golden Rule Insurance Company, together with certain responses from Golden Rule and together with certain other papers, documents, including some comments in the press into the record at this point.

[The information follows:]

The Burlington Free Press · Wednesday, July 1, 1992

Of ferrets, weasels and health care

Insurance company hires lawyers to protect its clients

By Betsy Liley
Free Press Staff Writer

MONTPELIER — The Golden Rule Insurance Co. has hired two Montpelier lawyers to ensure their 11,000 Vermont policyholders are protected by provisions included in a new law.

The health care reform bill passed this year prohibits health insurers from basing rates on health and age. That provision, known as community rating, led to Golden Rule's pulling out of the state.

The health bill guarantees that policyholders will receive comparable insurance coverage at no more than 15 percent more than what they now pay.

Saying they didn't want the state "to weasel out" of the protections, Golden Rule President J. Patrick Rooney said, "We're here to see that guarantee is kept."

Rooney brought two ferrets labeled "The Gov" and "The Commish" for Gov. Howard Dean and Banking and Insurance Commissioner Jeffrey Johnson, who pushed through the health reforms. The animals were meant as stand-ins for weasels, which the state classifies as wildlife and cannot be used as pets.

At what became a rowdy, confrontational news conference in front of the Statehouse, Rooney called the health insurance provision "essentially socialism" because it makes old and young Vermonters pay the same rates.

"We used to do community rating. We finally stopped because it was so unfair," Rooney said.

During the news conference, two men stood behind Rooney holding anti-Golden Rule signs. One, held by Chris Wood, read. "Golden Rule No. 1: Thou shalt rip off Vermont consumers. Golden Rule No. 2: If you can't rip off Vermonters, thou shalt weasel their way out."

Ted Cote, sporting a Gropper for Senate button, pushed Wood repeatedly through the news conference, trying to nudge him away from Rooney. "I didn't think it was very polite for him during a press conference to crowd the president of a large company," Cote said.

J. Patrick Rooney, president of Golden Rule Insurance Co. (left), and attorney Darrell Richey speak on the Statehouse steps Tuesday. Behind them, Chris Wood of Vermont Consumers Campaign for Health, protests against Golden Rule.

Wood is a board member of the Vermont Consumers Campaign for Health.

Later, Dean spokesman Glenn Gershaneck, state Sen. Cheryl Rivers, D-Windsor, and a Golden Rule agent from Rutland, Michael Moser, got into a heated argument surrounded by the media.

"There are a lot of reasons why people are picking on health insurers," Gershaneck said. "If health insurance was working we wouldn't be where we are."

"I think the way the governor characterized it (Golden Rule's departure) last week still stands. It seems like sour grapes," he said. "I think it's kind of a silly way to deal with a serious issue."

Gershaneck and Johnson said Vermont hoped to ensure universal coverage by spreading the risk among a greater pool of policyholders. "I think the issue of risk-spreading is now front and center in Vermont," Gershaneck said.

Moser said Golden Rule had a right to leave the state.

LEVEL 1 - 1 OF 1 STORY

Copyright 1989 UMI/Data Courier;
Copyright Business Press Inc 1989;
Business Dateline;
Indianapolis Business Journal

November 20, 1989

SECTION: Vol 10; No 32; Sec 2; pg 1B

LENGTH: 1305 words

HEADLINE: Golden Rule vs Rate Regulators

BYLINE: Alicia Carlson

DATELINE: Indianapolis; IN; US; North Central

BODY:

J. Patrick Rooney is on a crusade.

The chief executive officer and chairman of the board at Indianapolis-based Golden Rule Insurance Co. doesn't mind admitting that he and his firm are considered pushy and demanding by insurance commissioners in several of the 49 states where the company writes individual health insurance plans.

In fact, Rooney sees Golden Rule -- a company named for the biblical motto "Do unto others as you would have them do unto you" -- as being in a lonely battle over a constitutional ideal.

Rooney charges that insurance commissioners in several states are arbitrary in their dealings with individual health insurance companies. He believes that, in those states, insurance companies that ask for rate increases are being denied the requests on the personal whims of the commissioners or for political reasons, without any published standards based on state laws. And sometimes, even informal rules established by the commissioners aren't applied uniformly to all companies, Rooney says.

With no legal standard against which rate increase decisions can be made, Golden Rule is being denied the right to due process of law and equal protection guaranteed by the United States Constitution, according to Rooney.

Rooney wants insurance commissioners to establish fixed standards for setting rates, a cause over which he's willing to go to court.

Although he hasn't encountered any problems with Indiana's new insurance commissioner, John Dillon, Rooney says Dillon's colleagues in North Carolina, South Carolina and Iowa have already felt the sting of Golden Rule's lawsuits in recent months, and other states, including Massachusetts and West Virginia, have been threatened with legal action.

And Rooney announced last week that Golden Rule will file yet another lawsuit in federal court against another state in the coming week, although he would not disclose any details about the coming case.

Indianapolis Business Journal. November 20, 1989

In South Carolina and Iowa, lawsuits were dropped when agreements over rate increases were finally settled. In North Carolina, the suit was decided in favor of Golden Rule, and the insurance company is now suing the commissioner for several million dollars in damages based on the decision that the North Carolina insurance commissioner wrongfully withheld a rate increase from Golden Rule. That case may end up in court sometime next year.

Golden Rule is one of the last individual insurance plan providers in Massachusetts, but the company has stopped marketing new individual health insurance plans there. Although Golden Rule was recently granted a rate increase at the end of a longstanding dispute with that state's department of insurance, Rooney is maintaining Golden Rule's policy against marketing new policies there due to his belief that the state has not established any rate regulations based on legal standards.

State insurance commissions are not properly responding to companies that are desperate for rate increases because of high claim costs, Rooney says. Many insurance companies, including Golden Rule, are uneasy about providing health insurance in states where there are no fixed standards. Without standards, insurance companies cannot predict whether rate increases will be approved, he says.

"We're on a crusade because we feel that if this issue isn't fixed, there won't be any companies in some of these states to provide individual health insurance," Rooney says. "In those states that are attempting to regulate individual health insurance rates, we're simply saying that you have to have standards."

In many states, insurance companies that have provided individual health insurance plans in the past have already exited the market, leaving slim pickings for individuals who need coverage, according to Rooney.

Union Life Insurance Co. of Little Rock, Ark., Amalgamated Labor Life Insurance Co. of Kansas City, Mo, and Reserve Life Insurance Co. of Dallas, Texas -- all providers of individual health insurance plans -- all have left the individual health insurance market in recent months.

"Rather than get out, we're going to stay and fight," Rooney says.

Insurance companies and insurance commissioners need to share responsibility for the number of insurance companies fleeing the individual health insurance market, according to Paul Kopelcheck, president and CEO of Accordia Personal Benefits Inc., an individual health insurance subsidiary of Blue Cross/Blue Shield of Indiana.

Kopelcheck, a former executive with Reserve Life, says insurance companies need to monitor their insurance plans carefully to determine if and when rate increases are needed to make sure the company doesn't suffer financially, Kopelcheck says. Insurance commissions also need to be more prompt in enacting increases, he notes. If states aren't quick to respond to the rate increase requests, the companies sometimes face severe financial losses, or will leave the state's insurance market to prevent potential losses.

If insurance companies would present a united front to state insurance commissions on those issues, the problems could be minimized, Kopelcheck says

Indianapolis Business Journal, November 20, 1989

"I think Golden Rule, more than many companies, has the courage of its convictions," Kopelcheck adds.

Not everyone in the insurance industry agrees with Rooney's assessment of rate regulations. Chief among Rooney's detractors are the state insurance commissions with which he's tangled.

There's a general perception among many insurance commissioners that Rooney is a maverick who pays little attention to accepted insurance practices, according to one industry source, who spoke on the condition that he remain annonymous.

Most insurance companies agree to ask for only one rate increase a year, while Golden Rule has asked for up to three increases in one year in at least one state, according to the unnamed source.

Most insurance companies also abide by Iowa's request that rate increases be kept at a minimum, according to Kevin Howe, an Iowa Department of Insurance spokesman. Golden Rule is the only company that has complained to the department about Iowa's rate regulations, he notes.

Rising insurance premiums reflect increasing medical costs, but it's the insurance commissioner's job to balance those rising costs with the consumer's interests in keeping rates affordable. "That's where it's inevitable that there will be some conflicts," says Howe.

Rooney's conduct is unusual in a regulated industry, according to Susanne Murphy, deputy chief insurance commissioner of South Carolina. In South Caroline, in a series of confrontations, Golden Rule and the state's insurance commission negotiated rate increases.

Golden Rule is constantly on the offensive and has adopted aggressive tactics in South Carolina and other states, Murphy says. The company's behavior is unusual in an industry in which many companies try to be conciliatory toward regulatory bodies, she notes.

North Carolina's insurance commissioner, against whom a lawsuit is still pending, did not return phone calls before IBJ's deadline.

Rooney says that, despite the appearance of obvious self-interest in disputes between insurance commissioners, he's committed to a cause of higher principle. As a member of the board of directors for the Indiana Civil Liberties Union, Rooney says he's concerned about constitutional rights. In some states, insurance companies like Golden Rule are being denied their rights, he insists.

At insurance industry meetings and conventions, Rooney says other company executives express admiration for his efforts, although they decline to participate in his battle. Other companies may agree, but remain silent, while Golden Rule believes in fighting back, he says.

And he's not afraid of a lonely fight. "If you're doing the right thing, you're bound to be alone," Rooney says.

The Orlando Sentinel, Friday, January 31, 1992

Judge lets Gallagher lawsuit stand

By Adam Yeomans

SENTINEL TALLAHASSEE BUREAU

TALLAHASSEE — A state circuit judge Thursday refused to dismiss an Indiana-based insurer's lawsuit alleging that Insurance Commissioner Tom Gallagher defamed the company and hurt its business.

As a result of Judge Lewis Hall's ruling, Gallagher is expected to give a deposition soon to lawyers for Golden Rule Insurance Co. that his lawyers have resisted for months.

Gallagher

Golden Rule sued Gallagher in late 1990 after he attacked the insurer as a "bait-and-switch insurance company" and a "rip-off artist" in a TV ad during his re-election campaign.

The commissioner's ads were in response to the company's TV ads that accused him of trying to increase the price of Medicare supplement insurance by requiring insurers to base their premiums on five-year projections, a practice known as "trending."

Gallagher has said the company wanted to lure customers with low-priced policies and later increase rates dramatically — a practice he called bait and switch.

On Thursday, Hall refused to dismiss the company's allegations that it was defamed by Gallagher's ads. The judge agreed to dismiss allegations that Gallagher violated the company's civil rights.

Lawyers for Golden Rule said Gallagher was a political candidate when he made his statements, not a public official who otherwise would receive immunity from the allegations.

Gary Williams, a Tallahassee lawyer for Gallagher, said the commissioner was acting as an official when he made the statements in the ad and that they were related to insurance matters for which Gallagher is responsible. "You hold that position and title 24 hours a day," Williams told the judge.

John Cooper, Golden Rule's Tallahassee lawyer, argued that "it probably is tough to draw the line. That's why we have juries."

Gallagher was unavailable for comment Thursday. His spokeswoman, Jill Chamberlin, said a lawsuit such as the one filed by the company could potentially have a "chilling effect" on the ability of state officials to regulate companies.

"In Gallagher's case, he's going to continue to do his job regardless of whether litigation is filed against him," she said.

DENVER BUSINESS JOURNAL
April 10, 1992

Doing unto others?

Golden Rule fights to protect loophole in health reforms

By L. WAYNE HICKS

Despite widespread backing by the insurance industry, a key health care reform bill has been gutted after intensive lobbying of Colorado legislators by Indianapolis-based Golden Rule Insurance Co.

As originally drafted, Senate Bill 114 would have guaranteed access to health insurance for small businesses. It also would have closed a loophole in Colorado insurance regulations that lets Golden Rule pick and choose who it wants to cover.

That provision sparked a lobbying effort by Golden Rule that included hiring a Florida telemarketing company to call Colorado small-business owners and urge them to tell legislators to vote against the bill.

"There's more to this than meets the eye on why they're lobbying so hard," said Sen. Bill Schroeder, R-Morrison, sponsor of the bill.

Members of the insurance industry say they back the bill because it attempts to control the rising cost of health care.

But the bill was gutted last month by the House Business Affairs and Labor Committee. Deleted was any mention of a plan to guarantee employees of small businesses access to cost-effective health insurance policies.

Angela Sipe, public-policy analyst for Golden Rule, said her company opposes the bill because it would increase costs. She said Golden Rule is merely attempting to tell the Legislature of its own experiences in guaranteeing access to health insurance.

Please turn to page 15

Insurer defies industry's backing of small-business health reforms

Continued from page 3

Between 1981 and 1986, Sipe said, Golden Rule offered two comparable policies — one that required a look at a person's health history and one that didn't. Sipe said the plan that ignored health history wound up costing 50 percent more than the other.

Deflecting a question on how the original bill would have affected Golden Rule's business, Sipe said, "Our position is how it would affect small business."

But, according to supporters of the bill, who are lobbying to have it restored to its former state, passage of the original version of SB 114 would have cost Golden Rule a competitive edge.

Golden Rule picks and chooses among a company's employees, and insures only the healthiest of the group, according to industry sources. That process, known as "cherry picking," allows an insurer to collect premiums while paying out relatively little money in claims.

"It does provide them with some advantages," said William Lindsay, president of Englewood-based Benefit Management & Design Inc.

Some forms of cherry picking were made illegal last year, when the Legislature passed reforms requiring insurers that underwrite coverage for a small group to cover all employees who previously had insurance.

Because Golden Rule sells individual policies rather than group health coverage, however, the insurer's practice is allowed under one provision of the law.

"If you're a bad risk, you're not going to get covered" by Golden Rule, said Les Berry, director of public affairs for the Greater Denver Chamber of Commerce. The chamber, along with the National Federation of Independent Business and the Colorado Group Insurance Association, is part of a group called the Coalition for Insurance Reform, which is attempting to restore SB 114.

The original version of SB 114 would have required insurers to provide health insurance to all small-business employees as long as the employer paid part of the premium.

"From what I've been told," Schroeder said, "loopholes would have been closed."

Schroeder said he was surprised at Golden Rule's opposition to SB 114 because most of the industry backed the bill and was "not going out and trying to derail it."

Despite Golden Rule's heavy lobbying of Colorado lawmakers, the insurer does not have a large presence in the state. Golden Rule sold $12 million in premiums during 1990, accounting for just 1.4 percent of the traditional indemnity insurance market.

Charlotte Obs. 2/23/89

Insurance Company Claims N.C. Unfair

By JAY McINTOSH
Staff Writer

Golden Rule Insurance Co. is accusing the N.C. Insurance Department of unfair treatment in a dispute that will result in the biggest mass cancelation of health insurance policies in state history.

But an Insurance Department official says the agency was right in denying a 73.6% rate increase sought by Golden Rule.

Last week, Golden Rule announced it won't renew about 8,140 health insurance policies covering 20,000 people. The cancelations start Wednesday. Golden Rule sold only individual health policies in North Carolina, not group plans.

Under a plan arranged by the Insurance Department, Blue Cross-Blue Shield of North Carolina will offer policies to people who lose their Golden Rule coverage.

For some policy holders, Blue Cross-Blue Shield coverage will cost much more than Golden Rule's would have cost after its requested increase, said AndaOlsen, government affairs director for Indianapolis-based Golden Rule.

"It's hard to believe that Jim Long, as an elected official, can maintain public trust when he has driven one company out of the market, helped create a monopoly for another company (Blue Cross) and caused North Carolina citizens to pay even higher rates with the company he handpicked for them than they would have paid with their previous company," said Patrick Rooney, chief executive of Golden Rule.

Long is the state's insurance commissioner.

But Leonard Wood, N.C. deputy commissioner for life, accident and health insurance, said the Blue Cross coverage is comparably priced for most policy holders .

"The Blue Cross policy is a very rich benefit policy, and all things considered, the policy holder is going to gain," said Wood.

Golden Rule stopped selling the health policies last year and laid off most of its 20 Carolinas employees. Its one-person N.C. office, staffed by marketing manager LaDonna Williams of Charlotte, still sells life insurance and annuities in the state.

The News and Observer, Raleigh, N.C., Wednesday, Feb 22, 1989 · 19A

Illinois company drops N.C. health policies

By VAN DENTON
Staff writer

An Illinois insurance company is refusing to renew health insurance policies providing comprehensive medical coverage for thousands of North Carolina residents because of a rate dispute with Insurance Commissioner James E. Long.

Mr. Long said Tuesday that Golden Rule Insurance Co. of Lawrenceville, Ill., had notified the department it would not renew policies for 8,140 of its North Carolina customers. Such a move would leave some of those customers and their dependents — as many as 20,000 people — facing the loss of health insurance beginning in March.

The company's customers will have the choice of either finding new coverage or switching to Blue Cross and Blue Shield of North Carolina, under an agreement worked out between Mr. Long and Blue Cross.

While they also will face rate increases that could run as high as the 73.6 percent sought in some cases by Golden Rule, department officials said, customers will be assured of not seeing further rate increases for at least a year.

The dispute with Golden Rule centers on a long-standing Insurance Department regulation requiring health insurance companies to guarantee their rates for at least 12 months. The guarantee has been a department regulation under Mr. Long and his predecessor, former Commissioner John R. Ingram.

Mr. Long blamed the loss of coverage on "less than desirable practices" sought by Golden Rule, while an assistant vice president of the company, Kimathi Mohammed, said it was caused by "the obstinacy of Commissioner Long."

The commissioner said that of some 800 insurance companies providing accident and health coverage in North Carolina, Golden Rule is the only one that refuses to guarantee its rates.

"We felt this was in the public interest to stabilize health insurance rates for a 12-month period at a time," he said Tuesday in an interview.

But in a statement, Mr. Mohammed, the company official, said: "The N.C. Department of Insurance has shown a scandalous disregard for the well-being of the citizens of North Carolina by its refusal to grant Golden Rule needed rate increases in a timely fashion to offset the high claim costs the company is facing."

The commissioner said that he had refused to exempt the company from the regulation and from a second request that rate increases under dispute be settled by an arbitrator.

"I plead guilty to obstinacy because as I read the laws as enacted by the General Assembly I cannot give away the authority to set rates," Mr. Long said. "We are not going to let any insurance company run roughshod over the rights of our citizens."

He said the 73 percent increase sought by Golden Rule would have been the third in the last 12 months and that the company had implemented one increase without getting approval, in contradiction to state law.

Roger Langley, a senior deputy insurance commissioner, said that Golden Rule had increased its rates by 20 percent last spring and another 34 percent in the summer of 1988.

Under the arrangement worked out with Blue Cross, customers of Golden Rule whose health insurance policies are canceled can obtain coverage under the same provisions they had previously, Mr. Long said.

James E. Long

N&O
Feb. 24

Illinois health insurer assails Long over rate dispute

By VAN DENTON
Staff writer

The Golden Rule Insurance Co. on Friday criticized state Insurance Commissioner James E. Long, contending that his actions in a rate dispute had forced the company out of the health insurance market in North Carolina.

Company officials contended that the commissioner's actions would result in higher costs for its customers and less competition in the state's health insurance market.

Beginning March 1, the Illinois-based company will not renew policies for 8,140 of its North Carolina customers, a move that will disrupt insurance coverage for some 20,000 people when dependents are included. But Golden Rule customers will have the option of switching to Blue Cross and Blue Shield of North Carolina under an arrangement worked out by Mr. Long.

In a sharply worded statement, J. Patrick Rooney, chairman and chief executive of the insurance firm, said the actions of the state Department of Insurance had forced his company to stop providing major medical insurance coverage in the state.

"It's hard to believe," said Mr. Rooney, "that Jim Long, as an elected official, can maintain the public trust when he has driven one company out of the market, helped create a monopoly for another company, and caused North Carolina citizens to pay even higher rates with the company he handpicked for them than they would have paid with their previous company."

Mr. Long was attending an insurance conference in Boston and could not be reached for comment Friday. Deputy commissioner Roger Langley defended the department's actions in the case.

"Are we losing a quality company?" Mr. Langley said in an interview. "I think that is debatable. We want competition. We need more companies writing this coverage, but we need companies who are willing to treat North Carolina policyholders fairly. We don't believe Golden Rule was doing that."

The dispute was prompted by Mr. Long's refusal to allow Golden Rule to implement immediately a 73 percent rate increase for all its customers. The commissioner had approved the rate increase, but required that it go into effect only as customers renewed their policies, in effect delaying its impact on some until March 1990.

Kimathi Mohammed, an assistant vice president of Golden Rule, said that the company had been willing to guarantee the new rates for 12 months, but that it was necessary for them to go in effect immediately for all customers because of high losses in North Carolina.

But Mr. Langley said that if Mr. Long had allowed the rate increase to apply to all customers immediately, some would have seen their rates go up for the third time in a year.

Mr. Mohammed, who traveled to Raleigh Friday for a news conference that was canceled because of bad weather, said that Golden Rule customers would end up paying higher health insurance rates than if the company had won its full rate increase.

For example, he said that a 40-year-old Raleigh couple with a $500 deductible policy would pay $168.39 a month under the new Golden Rule rates, but would face premiums of $250.42 under Blue Cross, a 49 percent difference.

Mr. Mohammed said the Blue Cross rates were based on rates provided to insurance agents who had Golden Rule customers. Those rates could not be verified Friday because Blue Cross was closed due to the weather.

James E. Long

MONEY/AGRIBUSINESS

Fight over insurance review looms

Iowa Newspaper Association

DES MOINES — A state official has accused a lobbyist for an Illinois-based insurance company of threatening "an all-out fight" if Iowa Insurance Commissioner David Lyons failed to implement a new procedure for establishing health insurance rates.

A memo by Daniel Winegarden, deputy insurance commissioner, said a lobbyist for the Golden Rule Insurance Co. was prepared to spend "whatever is necessary" on both advertising and lobbying to obtain its favored standard of minimum guaranteed loss.

Winegarden said the lobbyist, who was not named, mentioned the figure of $600,000 in a telephone conversation with him.

"Minimum guaranteed loss ratio is used by three or four states in setting health insurance rates," Lyons said. Some companies are pushing for the concept on a national level, he said.

Under the system, an insurance company guarantees a loss ratio of a certain percentage on its policies. If the loss ratio is less than the guarantee, the insured receives a refund of the difference.

"This means their policies are not subject to any rate review for adequacy, excessiveness or discrimination in that state," Lyons said.

The guaranteed loss ratio proposal is a response to insurance departments that are slow in setting insurance rates, according to Lyons.

"Most of the guaranteed loss ratio concepts we've seen so far are probably a bad idea for Iowa for several reasons," Lyons said.

"First, the guaranteed loss ratio percentages are normally set fairly low," he said. "For example, most of the companies that are pushing this on a national level want a guaranteed loss ratio of 55 percent on their policies.

"This means they are required to meet the minimum ratio, paying 55 cents on the dollar of every policy. The existing loss ratio for a majority of Iowa companies is significantly higher, meaning they pay more to the insurance consumer than 55 percent on their claims.

"Secondly, we don't have the problem in Iowa that prompted other states to consider this," he said. "In Iowa, we have the shortest turnaround time on rates and forms for approval in the country, which is five days."

In Iowa, as in most states, health insurance rates are filed and are approved by the commissioner before they go into effect. Health insurance rates are adjusted by using past experience to predict future losses.

Iowa and other states believe that these rate adjustments are also subject to commissioner review and approval, Lyons said.

In proposed legislation, Lyons is asking lawmakers to reaffirm his adjustment authority. Tuesday, the Senate commerce committee approved a study bill that would reaffirm the commissioner's rate review authority.

TERRY E. BRANSTAD, GOVERNOR

INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

TO:	Governor Terry E. Branstad President of the Senate Michael E. Gronstal Speaker of the House Robert C. Arnould Senator Patrick Deluhery, Chair Senate Commerce Committee Representative Steve Hansen, Chair House Commerce Committee Members of the Iowa Legislature
FROM:	Daniel Pitts Winegarden, First Deputy Insurance Commissioner
DATE:	January 31, 1992
RE:	Regulatory review of health insurance rates.

Commissioner Lyons' first rule is, "Do the right thing for the right reason." I need to share some background with you so that you understand the Division's position on an issue you may be called on to resolve, and to assure you I am following the first rule.

Health insurance rate review statutes (including Iowa's) typically provide that rates must be filed with and approved by the Commissioner prior to use. Health insurance rates are adjusted by using past experience to predict future losses. Iowa and other states believe that these rate adjustments or rerates are also subject to Commissioner review and approval. Iowa has historically exercised this rerate authority. Some companies take the position that the Commissioner's original review can be made meaningless six months or a year later by a unilateral rate adjustment not subject to prior Commissioner approval. Iowa domestic companies accept Iowa's current practice of prior rate review and approval because we do it promptly and fairly.[1]

An alternative to prior rerate review and approval has been advocated by some in the industry, including Golden Rule, an Illinois domestic insurance company with its principal place of business in Indianapolis, Indiana. **The Iowa Division of Insurance opposes minimum guaranteed loss ratio legislation as advocated by Golden Rule.** The issue was first raised last year by Golden Rule during session. Because it was such a major departure from current practice, the Division asked Golden Rule that it be deferred for study over the interim.. We agreed to review the concept if the concerns of the Division could be adequately addressed and if consensus of the Iowa industry could be developed. **This fairly established and agreed to minimum threshold was not met.** While members of the Iowa Life Association studied the concept, no consensus of Iowa domestic health insurers was reached on the Golden Rule proposal.

I did not receive any work product from Golden Rule during the interim. But today I received a call from Golden Rule's chief lobbyist threatening an all out fight if the Commissioner did not acquiesce to their demands. Steven Baer, the company's lobbyist,

LUCAS BUILDING / DES MOINES, IOWA 50319 / 515-281-5705

stated that Golden Rule is prepared to spend whatever is necessary on both advertising and lobbying to prevent the Iowa Insurance Commissioner from exercising continuing rate review (rerate authority) and to obtain its favored standard of minimum guaranteed loss ratio. The figure of $500,000 was mentioned.

The Division's 1992 regulatory bill includes an express provision to review rerates. This reaffirms rerate authority traditionally exercised and eliminates any chance of costly litigation. Continuing rate review is a regulatory standard generally accepted by Iowa public officials.

Golden Rule has announced their intentions to block reaffirmation of the rerate authority and get their own substitute amendment for minimum guaranteed loss ratios.

I hope you can understand that Commissioner Lyons cannot accede to Golden Rule's ultimatum.

I ask for your support of the Commissioner's position, and assistance in the passage of the Division's insurance reform measures this year.[2]

[1] In fairness, not all states approve rates within the strict time limits used by Iowa. Even companies that accept Iowa's rerate authority, object to the way some states exercise rerate authority, and thus object to explicit rerate authority on principle. Many state have backlogs of months in rate review and approval. Some withhold action even when rerates are reasonable. Iowa Insurance Division standard practice is to respond to a rate filing within 5-7 days. We hold ourselves to a strict standard with a statutory "deemer" provision that says, "a rate is deemed approved unless objected to" within a limited number of days. Iowa uses a staff actuary to assure that company requested rerates are fair and justified. Even recognizing that some company objections have merit in other states, Iowa is not a problem, and the lack of explicit rerate authority subjects the Iowa Commissioner to the prospect of costly litigation to reaffirm existing authority.

[2] Iowa domestic insurers provide coverage for well over half of the Iowa market. Iowa companies continue to work for consensus on an amendment to the mutually agreed upon rerate language contained in the Division's bill. The amendment would permit the use of mutually acceptable, objective rerate review standards. If work is completed on the amendment it will be offered this session.

Golden rule

TERRY E. BRANSTAD, GOVERNOR

INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

TO: Senator Richard Varn, Chair
Senate Standing Commerce Subcommittee on Insurance
FROM: Dan Winegarden, First Deputy Dan
DATE: March 3, 1992
RE: Guaranteed Minimum Loss Ratios.

You asked for a summary of the technical arguments against guaranteed minimum loss ratios as proposed by Golden Rule. I am working off of last year's proposed bill by Golden Rule. The company has, as previously noted, absolutely failed on its commitment to develop a proposal for review by the Insurance Division over the interim. I do not know what they will offer tomorrow. This is a compilation of comments received from:

1. Bob Howe, Deputy Commissioner and Chief Examiner, President of the Society of Financial Examiners and a nationally respected expert on insurer financial oversight.
2. Roger Strauss, Bureau Chief of Life and Health, whose bureau is primarily responsible for the review of rates and forms for compliance with Iowa law.
3. Klete Geren, the Division's Life and Health actuary, responsible for rate analysis.

Golden Rule's proposal has received extensive review and is unanimously opposed by the Division's experts and Iowa industry. Some of the reasons include:

- **Rerate review and approval is working for Iowa consumers and companies.** Iowa has an adequate, but not excessive rate structure that continues to work well. Iowa domestics represent over half of the insured market and support the Division's rerate authority. Recomfirmation of rerate authority assures we do not waste scarce state funds on an unnecessary lawsuit to confirm accepted public policy.
- **Rate review is for three reasons, not just to prevent excessive rates.** The Division reviews rates on three basis:
  - **Rates cannot be inadequate.** (Protect the solvency of the company.)
  - **Rates cannot be excessive.** (Rates must be reasonable in proportion to the benefits provided.)
  - **Rates cannot be unfairly discriminatory.** (Underwriting decisions must be supported by actuarially sound -- statistically valid -- data. Arbitrary and capricious rate setting by companies is not desirable.)
- **Not the national standard -- Accreditation concerns.** Golden Rule's proposal does not fully address the State's legitimate interest in reviewing rates on all three grounds. Minimum guaranteed loss ratios as advocated by Golden Rule are not

LUCAS BUILDING / DES MOINES, IOWA 50319 / 515-281-5705

supported by the National Association of Insurance Commissioners. There may be concerns regarding Iowa's hard won accreditation by the NAIC or attendant insurer solvency issues if such mechanisms were adopted. This is a critical question Golden Rule failed to answer by not following the agreed upon procedure. Golden Rule implies there is an NAIC model on this topic. Untrue. The American Academy of Actuaries has a model submitted to the NAIC, which was not accepted as a model. Further, the NAIC is developing a comprehensive rate review model that may include objective standards, but is far different than the minimum loss guarantee proposal advocated by Golden Rule. **Real danger of Iowa being out of the regulatory mainstream if we accept Golden Rule's proposal.**

- **Answers a problem Iowa does not have.** Guaranteed minimum loss ratios are essentially a pre-approval mechanism for future rate increase which relieves the company of any continuing rate oversight by the Commissioner of Insurance. Given the rapid pace of health care cost inflation, it may make sense in states where companies do not receive timely review of rate increase requests or rates are politicized. That is not the case in Iowa. The Division gives prompt turnaround time on both form and rate requests. There is no need for this automatic mechanism to avoid delays as turnaround time is never longer than 10 days, and in most cases is 5 days or less. The use of an on-staff actuary assures uniformity of analysis and treatment between companies.

- **Ability to game the system.** These rules were drafted by a company with a purpose. Not all of the nuances may be fully disclosed. In any case, the Division's experts are very concerned about the ability to manipulate reserves and other methods to game the system so that the loss ratio is achieved or exceeded and thus refunds are never made or are minimal. A good question to ask the company is how much has been refunded to consumers to date (both in total dollars and as a percentage of premiums collected).

- **Potential to low-ball premiums to buy market share.** The proposal does not prevent low-balling of the premium knowing that the guarantee and loss ratio concept will automatically bring the premiums up to offset the initial low-ball premium. This is a special concern in health care were increasing age or change in health status may prevent a person from exercising real choice to change insurers once committed. The threat of being denied coverage for pre-existing conditions exist whenever consumers switch sources of coverage. This is one reason the Division's proposed reforms in the small group market are targeted at continuity and portability of benefits.

- **Low loss ratio.** Golden Rule proposes that only 55% of premium dollars be returned to consumers in benefits. In comparison, the current market average loss ratio is 79.89% for the top 109 health insurance companies representing 97% of the

market. 67% when the top writer, Blue Cross/Blue Shield is taken out. 74% for only Iowa domestic carriers.

- **Dependence upon independent auditors and private actuarial opinions.** As enforcement mechanisms, standing alone, the Division does not have whole-hearted confidence in either independent auditors and private actuarial opinions. Regulatory oversight of both the reviewed entity and the audit or opinion letter are necessary to assure compliance. Savings & Loans go insolvent on a regular basis with independent audits attesting to their financial strength.

  The range of reasonable actuarial opinion can be equally wide. One reason the Division retains actuaries on staff is to assure consistency of analysis between rate filing reviews, and thus equality of treatment between companies. Golden Rule's proposal assures that similarly situated companies will have different results.

- **Who gets the refund?** If a refund is required, to whom would it be paid? How does the company locate the policyholder, especially since some people have died, some have moved, and some have lapsed their policies. A better question yet, how does the Division assure payment is made? The whole point of the proposal seems to be to escape regulatory oversight. What happens to the money which cannot be refunded, for whatever cause?

- **Iowans will be forced to share the loss experience of other more expensive states.** The Golden Rule proposal has a $1 million threshold for the pool of risk subject to the loss ratio.

  According to the Commissioner's 1991 report to the Governor covering the policy year 1990, there were only 4 domestic companies that had premium volumes in excess of $1,000,000 for ALL individual accident and health business (much less a single block of business). (Principal, Farm Bureau Life, National Travelers, and American Republic.) There were 30 non-domestic companies that had Iowa volume in excess of $1M. Each of these companies has multiple forms. It is doubtful whether any one policy form would ever reach $1 million in Iowa premium by itself. Therefore, according to Golden Rule's proposal, the rate increase, the refunds or payments would result from experience pooled across several states. The Division's actuary notes that it will be impossible to assure Iowans do not subsidize higher losses in other states. This is a very likely outcome given Iowa's relatively favorable health care costs. **The loss ratio experienced by Iowans will actually be less than that promised.**

- **Inconsistent with rule that Iowa rates shall be based upon Iowa experience.** Iowa has successfully enforced a policy that Iowa rates must be based upon Iowa loss experience to assure that Iowans get the benefit of cost containment, favorable cost and utilization patterns and tort reform. Why should Florida consumers get the benefits of Iowa's relatively low health care costs, in part attributable to tort reforms

limiting medical malpractice exposure? (Medical malpractice rates were reduced 40% on average within the last two years in response to Iowa tort reforms and a market review by the Iowa Division to assure that reforms were reflected in rates.)

Iowa has in fact taken a strong stance on California's Proposition 103 to assure that refunds to California consumers do not come from surplus or reserves attributable to Iowa consumers. Given this consistent policy, Iowa should not support a system that permits multi-state losses to impact the rates Iowans pay. Right now we control our own destiny. This gives the rudder away.

- ☐ **Golden Rule has half-one percent of the Iowa accident and health insurance market.**
- ☐ **Iowa domestic insurers do not support the Golden Rule Proposal.** Iowa domestic companies represent over half of the Iowa market oppose Golden Rule's proposal.
- ☐ **Threatens the cooperative partnership that has produced nationally low insurance rates and high insurance business growth.** Approval of the Golden Rule proposal would fly in the face of the cooperative, consensus based approach that has been the distinguishing feature of Iowa's insurance regulatory and business climate.

The Division is working with the Iowa industry on reducing to paper objective rate review criteria, a process that might produce something similar in some aspects to guaranteed minimum loss ratios. That is an on-going project and will continue after the requested legislative re-confirmation of re-rate authority. For the time being, consistency is relatively high due to the actuarial talent the General Assembly funded in recent years for the Division. There are a bundle of outstanding questions we had intended to ask Golden Rule in the course of the agreed to interim project. We never got that opportunity. The Division simply has not reached any level of comfort to acquiesce to a major change in the form of rate regulation with unknown consequences for Iowa consumers.

A good old rule of thumb applies, "If it ain't broke, don't fix it." The Division asks that rerate authority be expressly stated to avoid unnecessary litigation and that Golden Rule's minimum guaranteed loss ratio be rejected.

THE WALL STREET JOURNAL FRIDAY, MAY 27, 1994

New York Finds Fewer People Have Health Insurance a Year After Reform

By LESLIE SCISM
Staff Reporter of THE WALL STREET JOURNAL

Almost one year after New York State adopted stiff insurance reforms, fewer people have health-care coverage than under the old system.

The surprising decline provides ammunition to supporters of nationwide mandatory insurance, and could prove troublesome for advocates pushing for incremental insurance reforms.

Under New York's system, insurers are required to offer one-size-fits-all pricing, a method that sharply decreased rates for older, sicker people but increased them for others. The law also forces insurers to take all comers, and, as a result, some insurers contend that disproportionate numbers of young, healthy people are dropping coverage on the assumption they can buy it later if needed.

With increasingly fewer healthy people counterbalancing the sick, the result, according to the insurers, is the start of an upward spiral in rates for those still in the pool. If the trend continues, insurers contend, the very people that the program was intended to help could again be priced out of the market.

Crumbling Barriers

"There should have been a substantial gain in people insured [in New York] because a number of barriers for people to be insured came down," says Robert Laszewski, a partner with Health Policy & Strategy Associates, a Washington consulting firm. But the abrupt increase in rates for young, healthy people has "affected the ability of New York to achieve a lower-cost pool. Now we may have a pool in New York skewed toward the sick, and in the long run that doesn't help the consumer."

Ronald Pollack, executive director of Washington-based Families USA Foundation, a consumer group that backs President Clinton's plan of mandated coverage, adds: "New York's experience gives very little comfort to those who just want incremental insurance reforms." Mr. Pollack insists that reforms, in isolation, "can't keep insurance affordable and available for families."

New York's effort is one of the nation's most sweeping attempts at reform and is closely watched by national policy makers. New York Insurance Department figures show that, overall, 1.2% fewer people – or 25,477 fewer people – were insured individually or in small-employer groups as of Jan. 1, nine months after the law, which covered those categories, took effect. The decline was particularly pronounced among individual policyholders – 12.4%, or 43,666 people. The figures respresents people insured by conventional insurance companies, health-maintenance organizations as well as Blue Cross/Blue Shield.

Insurance-department officials downplay the slight drop in overall enrollment, citing a "disruptive phase-in period." As for the steeper drop in individual coverage, they suggest some people previously covered individually are now in small groups, perhaps because their employers were prompted to add coverage.

'Unqualified Success'

New York Insurance Superintendent Salvatore Curiale calls the state's effort an "unqualified success" because it opened the system to those needing insurance the most. "The reason for all the effort to portray this as a failure is because the health-insurance industry is deathly afraid it will be taken up as a national policy," Mr. Curiale says. "What they're afraid of is that their profits will decrease" if they can't make money "on the backs of young, healthy people."

Many insurance companies that strongly opposed the New York law say their individual and small-group businesses have always had thin profit margins. Although they are allowed under the law to raise rates anytime they wish, the insurers contend that forcing them to take on a disproportionate number of less-healthy policyholders makes it even tougher to turn a profit, making rate increases necessary.

The insurance industry's practice of rejecting sick people, or charging them exorbitant rates, has long been one of Hillary Clinton's biggest complaints. But her calls for change have generally been in the context of sweeping reform that would bring all Americans into the health-care system, mostly by forcing employers to pay for premiums. The debate over insurance-underwriting practices has revved up recently as some leading legislators have suggested that Congress enact moderate reforms now and revisit the issue of a massive system overhaul later.

'Bailing Out'

In New York's case, the state adopted a "community rating" system, so-named because insurers must charge all people within given communities the same price regardless of such factors as age and medical condition. While considered a revolutionary effort, the state still allows insurers to refuse to cover prior medical conditions during an individual's first 12 months of coverage. The idea is that the exclusion will induce healthy people into the system before they get sick.

But Cecil Bykerk, chief actuary for **Mutual of Omaha**, which along with HMOs and Blue Cross/Blue Shield provides indi-

Please Turn to Page A4, Column 3

New York's Reform Leaves Fewer People With Health Care

Continued From Page A2

vidual coverage in New York, says young, healthy people are nonetheless "bailing out." The average age of the company's New York policyholders has gone up 3.5 years under the new law, to 45 years, he says. The average New York claim more than doubled, to $7,900, while the company's claims nationally rose just $400 to $3,800.

The result at Mutual of Omaha: average 35% rate increases in New York this year, which come on top of increases for some young, healthy people of as much as 79% when the law took effect in April 1993. Before the reform, a 25-year-old male in Albany paid Mutual of Omaha $64.45 a month for coverage, and a 55-year-old paid $141.79; in the law's first year, each paid $107.33, and, with the newest rate increase, the bill is $145.10.

At **New York Life Insurance** Co., a small-group insurer, the average age of insured New York employees is up three years. Chubb LifeAmerica, a unit of **Chubb** Corp. that also sells small-group insurance, says people over 50 years old now represent 26% of New York enrollment, up from 20%.

"There's no question we have an adverse-selection cycle setting in," says Seymour Sternberg, a New York Life executive vice president, calling the situation "very unstable."

John Swope, president of Chubb LifeAmerica, meanwhile, speculates that some small employers with mostly young workers ended coverage because of the rate increases imposed when the law took effect, while employers with older workers "grabbed it because it was such a bargain."

At Chubb and New York Life, rates are jumping more than 20% this year. But Mr. Curiale says some small-group insurers with double-digit increases underpriced their policies last year and are playing catch-up. He says more representative increases are in the single-digit range.

For now, the state has no plans to reconsider the law, saying the problems are overdramatized. "The figures still don't show the system isn't working," Mr. Curiale says. "There's no doubt that there are younger, healthier people who decided not to pay the premium increases. But you can extrapolate that these are people who can get back into the system if they want to."

Spiraling health-care costs create self-destruct policy

Jane Bryant Quinn

Staying Ahead

This is the first of two articles on the death spiral in individual health insurance.

NEW YORK — Call them Sam and Sallie Brown. They don't want to use their real names, but their story stands as a warning to anyone buying individual health insurance.

They find themselves trapped in what, to them, is a "death spiral" policy. That's the industry's all-too-knowing name for health-insurance coverage that is programmed to self-destruct.

In the early years, these policies look great. They're cheaper and better than those offered by the competition. That's what attracted the Browns nine years ago, when they bought a major-medical policy from the Time Insurance Co. in Milwaukee.

Time's John Krick, senior vice president for the individual medical line, acknowledges the industry's death spiral problem, but strongly rebuts the Browns' opinion that Time participates in it.

In the beginning, the Browns paid $309 per quarter for their coverage. At the time they were nearing age 50, living in Arkansas and raising cattle.

Today they're near 60 and facing some costly health problems. In January, their premium rose to $1,654 per quarter — up 30 percent from last year's price and up 435 percent from what they paid in 1983.

The premium-increase letters that Time sends to the Browns pin the blame on rising medical costs. It's more than that. It's a system of writing health insurance in America that skims off the good risks and clumps the sick together in policies that, as time passes, will gradually grow unaffordable.

When you buy individual health insurance, you assume that you're pooling your fortunes with thousands of others. Those who stay healthy and make few claims help hold down the cost for those who get sick.

That works as long as younger and healthier people keep coming into the pool. What you don't know, however, is that your insurer may close your policy to new buyers. That happened to the Browns and is how a death spiral usually begins. (Alternatively, the pool may stay open but your premiums may go up faster than the premiums charged to the newer buyers.)

The Browns bought Time's policy Form 670. It was sold in Arkansas only in 1983, Krick says. Later, it was combined with several other small pools, into a single group that was closed in 1985. For more than six years, no new blood has been added.

As the people with Form 670 age, the number and size of their claims goes up. To cover those claims, Time escalates the premium increases. The healthy people caught in that pool soon switch to cheaper policies — including, occasionally, new policies from Time.

That leaves more and more people like the Browns, who have medical problems and cannot switch. As premiums rise even higher, some of these people start quitting, too, because they can't afford the price. As of last July, only 1,744 people in Arkansas were still in the pool that included Time's Form 670. In the single year ending last July, 400 policyholders left.

I'm not picking on Time Insurance in particular. Golden Rule Insurance in Indianapolis also keeps starting and closing policy forms, as do many other health insurers.

Both Krick and Golden Rule's chief actuary, John Hartnedy, say the forms keep changing to make room for policies with better benefits. Time doesn't cancel its older policies, as death spiral companies can do, Krick says. Instead, they're combined with other closed pools. Hartnedy adds that's it's unfair to newer Insurance buyers to have to help pay for people who have been in the pool for a while. That's contrary to traditional insurance thinking, which truly believed in spreading the risks.

Both insurance companies say they avoid charging longer-time policyholders too much more than they charge the new people coming in the door. Depending on which rate card you look at, the Browns are paying either 16 percent or 36 percent more than people their age buying similar benefits new — which sounds like a lot to me.

Arkansas Insurance Commissioner Lee Douglass told my associate, Amy Eskind, that he hasn't heard any consumer complaints about death spiral health-insurance policies — most likely because consumers don't know what they're up against.

A couple of years ago, Wyoming protected longtime policyholders by preventing insurers from walling them off from the newer pools when setting rates. Why don't the other states wake up?

NEXT SUNDAY: What to do.

Jane Bryant Quinn writes her column on consumer issues for the Washington Post Writers Group.

New Hampshire State Senate News

State House, Room 302, Concord, New Hampshire 03301

FOR IMMEDIATE RELEASE

DATE: MARCH 7, 1993

FOR INFORMATION CONTACT: DAVID HARRINGTON
SENATE INFORMATION OFFICER
(603) 271 - 2111

SHAHEEN: GOLDEN RULE REPRESENTS EVERYTHING THAT IS WRONG WITH HEALTH CARE IN AMERICA

CONCORD - State Senator Jeanne Shaheen, D - Madbury, today charged the Golden Rule Insurance Company, headquartered in Indianopolis, Indiana, with pandering to fears by willfully misrepresenting Senate Bill 711 as a measure which would dramatically increase the cost of health insurance in New Hampshire. Shaheen made her charges in response to a recent advertising campaign launched by the company to defeat the legislation.

"Golden Rule has resorted to lies and half-truths in their attempt to defeat this legislation," said Shaheen. "For example, they have insinuated that premium costs could rise 170% if the bill is passed, when in fact the legislation stipulates that any increases would be limited to no more than 25% annually. And in fact, rates will decrease for many people."

"This out-of-state company writes a little more than 1% of the health insurance policies issued in our state and those policies are only issued to people it deems healthy and unlikely to file a claim," said Shaheen. "With such a small part of the market, I can only assume that they are reaping obscene profits in New Hampshire. Otherwise, Golden Rule would not be filling the airwaves with slick advertising produced on Madison Avenue intended to scare the people on main street."

"These out-of-state hucksters could care less about New Hampshire's citizens, let alone their health. Far from following the golden rule, this company breaks all the rules to make sure the gold goes to their bottom line," said Shaheen.

"I've been very encouraged by the willingness of the three largest health insurers in New Hampshire not only to support this legislation but also to further its progress. It would be a shame if their good work were to be tainted by the deplorable conduct of Golden Rule. It is precisely the behavior of companies like Golden Rule that makes health care reform such an urgent priority."

Golden Rule

ERIC E KEEFE
523 WINNACUNNET RD
HAMPTON NH 03842-2771

April 25, 1994

RE: 053711283

Dear Insured:

Several weeks ago I wrote to tell you about an expensive health insurance law the New Hampshire legislature is considering.

The bill is Senate Bill 711 (SB 711). It includes guarantee issue and modified community rating.

In my last letter, I explained that the combination of guarantee issue and community rating will cause dramatic increases in premiums for most people, particularly the young.

Several customers called and wanted to know what their actual increase would be. I thought you might want to know too, so I asked our actuaries to estimate your premium increase.

The current premium for your coverage is:	$64.47	monthly
Final premium if SB 711 passes:	$129.61	monthly

Your final premium represents the cost of SB 711 when the legislation is fully implemented. It does not include estimates for increased costs due to inflation and medical costs. (This increase is after the phase-in period has been completed.)

As you know, young people generally have lower incomes; older people have higher incomes. Nonetheless, if SB 711 passes, young people will pay extra to lower the cost for

(See reverse side)

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
(317) 297-4149

Mr. Keefe
Page 2
April 20, 1994

older people. This legislation is really a tax on younger people.

SB 711 has passed the Senate and is currently in a House subcommittee. It has the support of the Governor and a number of legislators. I believe those who support the legislation have been misinformed about its effects on people like you who buy individual insurance.

Similar legislation was passed in New York and has had a devastating effect for people under the age of fifty.

This legislation affects you and your family. Insurance companies will survive because they pass the cost on to the customers. It is you who will end up paying for this legislative scheme.

You can defend yourself by informing legislators of the consequences of this legislation. Addresses for all representatives are attached. If you need help identifying your representative, call 1-800-866-2145.

Write your representative. Explain what will happen to you if SB 711 passes. Ask your representative to vote against SB 711.

Sincerely,

Lee Tooman

Lee Tooman
Government Relations

Attachment

PS: This legislation includes notions similar to those in Democratic President Bill Clinton's health care plan.

EDGAR R. LANTIS

ATTORNEY AT LAW
ADMITTED IN INDIANA & MICHIGAN

5767 West 74th Street
Indianapolis, Indiana 46278

(317) 291-3654
Fax (317) 291-0696
Home (317) 578-7677

April 27, 1994

Senator C. Jeanne Shaheen
73 Perkins Road
Madbury, NH 03820

Re: Public Comments Regarding Golden Rule Insurance Company on April 21, 1994

Dear Senator:

This office represents the interests of Golden Rule Insurance Company, an Illinois corporation authorized to transact the business of insurance in the State of New Hampshire.

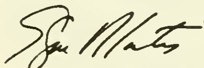
I have been asked to contact you regarding your comments before the House Commerce, Small Business' and Consumers Affairs Committee on Thursday, April 7, 1994. Your statements, as reported by the Foster's Democrat, include:

> "Golden Rule has resorted to lies and half-truths in an attempt in defeat this legislation;" and

> "These out-of-state hucksters could care less about New Hampshire's citizens, let alone their health. Far from following the golden rule, this company breaks all the rules to make sure the gold goes to their bottom line."

These statements are false, malicious and defamatory and as such represent libel per quod, if not libel per se. Similar future comments, if made outside the protective cocoon of legislative chambers may be actionable and appropriate for consideration by a court of competent jurisdiction.

Sincerely,



Edgar R. Lantis

ERL:lsa

cc: Suzanne E. Katt
Garry Rayno

c:\N-Hampshire\L.f\Shaheen.1

THE COLUMBUS DISPATCH
Copyright 1989 The Dispatch Printing Co.

DATE: FRIDAY *February*3, 1989
PAGE: 01F EDITION: FINAL
SECTION: BUSINESS LENGTH: MEDIUM
SOURCE: By Barnet D. Wolf
Dispatch Business Reporter

INSURANCE FIRM EXERTS PRESSURE IN RATE-HIKE BID

An Indiana insurance company that was rebuffed in its attempt to raise thousands of Ohioans' health insurance premiums by 86.4 percent without a rate review apparently is now trying to gain the hike through political pressure.

So far, however, the tactic does not appear to be working.

*GOLDEN*RULE*Insurance Co., of Lawrenceville, Ind., filed on Jan. 23 for the rate increase that would take effect March 1. The Ohio Department of Insurance decided, however, that a hearing was necessary due to the magnitude of the increase and past rate disputes with the company.

The hearing is set for Feb. 15.

Even in Columbus, a city rife with lobbyists,*Golden*Rule's*recent actions might be considered brazen by some. However, the insurer's outside counsel, Harry J. Price, said what some may perceive as pressure "was an effort

created by our inability to get a meeting with the department" to resolve their differences.

But Neil Rector, the ODI's deputy director, claimed the only time the department refused to talk with the insurer was Jan. 25, when he said*Golden* *Rule*delivered "an ultimatum": Approve the rate increase in two days or health policies covering 40,000 Ohioans would not be renewed.

"We just couldn't do that without a thorough review," Rector said. "We decided we don't want to negotiate with terrorists."

The latest salvo began last week, when*Golden*Rule*asked William Moreau, chief of staff to Indiana Gov. Evan Bayh, to set up a courtesy meeting last Friday with aides to Gov. Richard F. Celeste to discuss the dispute.

DURING THE meeting,*Golden*Rule*representatives warned that unless actior was taken to force Ohio insurance director George Fabe to back down on the review dispute, the insurer would begin sending policy cancellation letters to policyholders, according to Linda Ammons, who attended the meeting.

Ammons, Celeste's executive assistant for a year, called the tone "threatening" at times. "In the time I've been here, I've never had this happen," she said.

Price said*Golden*Rule*was only attempting to convey that without the rate increase the insurer would lose $3.8 million in Ohio during 1989. "The

company made a decision that it could not wait past March 1" to get the rate increase, and that it would be forced to cancel the policies because it could not incur the loss.

The aides told*Golden*Rule,*however, that the matter would need to be resolved with ODI.

*Golden*Rule*began sending policyholders non-renewal letters Saturday, according to ODI. One letter shown to State Rep. Wayne Jones, D-Cuyahoga Falls, blamed Fabe for the problem. Some angry letters and phone calls followed from policyholders and*Golden*Rule*agents to legislators.

JONES, WHO was ODI deputy director before becoming a legislator, agreed to meet some*Golden*Rule*officials, including Chief Executive Officer Patrick Rooney. But Jones told the group that pressure would not work.

"If you think you're going to get the legislature to call on (Fabe) to approve an 86 percent rate increase, you're crazy," Jones recalled saying.

The question of whom has been doing what unto others actually began in August, when the insurer sought hikes for two rate groups.

While*Golden*Rule*indicated the increases were about 36 and 20 percent, respectively, Rector said, "buried in the actuarial data" was language to allow "trend adjustments" that could boost rates up to 18 to 20 percent more without ODI approval.

The rate hikes were denied.

RECTOR SAID a series of meetings led to the approval of one request, boosting premiums on Jan. 1, although the hike was chopped from 36.3 percent to 28.1 percent and the "trend adjustment" language removed.

The insurer made a new filing for the other rate increase, but that was denied because it again included the trend adjustment, Rector said. After it was refiled Jan. 23, a hearing was slated for March 2, but that was advanced because an ODI actuary said his study would be completed by then.

Fabe said ODI has talked with other insurers about acquiring the business of*Golden*Rule*customers whose policies are cancelled.

KEYWORDS:*GOLDEN*RULE*INSURANCE CO.

MEMORANDUM

TO: The Honorable Robert W. Ney
Ohio Senate

FROM: George Fabe

DATE: February 2, 1989

RE: Golden Rule Insurance Company

On January 23, 1989, Golden Rule Insurance Company ("Golden Rule") filed a request for an 86.4% rate increase on their comprehensive major medical expense policy form GR1-H-1.2. Golden Rule wants us to approve this increase without adequately reviewing it. When we insisted on reviewing the rate increase carefully, Golden Rule began to seek a POLITICAL solution to a regulatory problem.

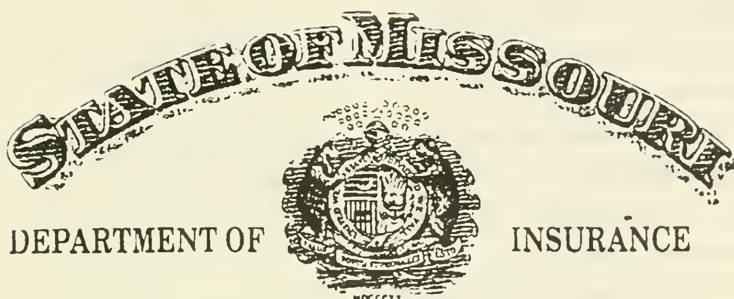
A public hearing on the increase is necessary because of the magnitude of the requested rate increase and because of questionable prior rate filing practices by Golden Rule. We recently learned that Golden Rule has made numerous rate filings which on the surface were sound. Buried in the filings, however, were "trend adjustments" that allowed Golden Rule to increase its rates by 20% annually without Departmental approval.

Golden Rule has tried to use political pressure to get us to approve their current filing without adequate review and a hearing. Golden Rule informed the Department on January 25, 1989 (2 days after they made the filing), that if the Department did not approve the filing by January 27, 1989, Golden Rule would nonrenew all Ohio policyholders. Golden Rule's threat does not change our regulatory obligation (ORC 3923.021) to review the filing and determine whether it is justified. We are working with other insurance companies to get backup coverage for Golden Rule policyholders, including those with preexisting conditions, in case Golden Rule carries through with its threat.

Golden Rule also has made inaccurate statements about the way the Department has treated them. Contrary to what they say, the Department never agreed to approve Golden Rule's rate increase without a hearing. In addition, Golden Rule has said that we refused to meet with them. I have personally met with representatives from Golden Rule three times, including a meeting with Patrick Rooney (CEO of Golden Rule). We have also had numerous telephone conversations with Golden Rule.

To resolve the problem, we offered Golden Rule an expedited hearing to be held on February 15. Golden Rule will mail notice of the hearing by the end of this week.

GF/NKR/wkm



P O Box 690, Jefferson City, Mo 65102-0690

STIPULATION OF SETTLEMENT
AND VOLUNTARY FORFEITURE

It is hereby stipulated and agreed by Lewis E. Melahn, Director of the Missouri Department of Insurance, and Golden Rule Insurance Company, hereinafter referred to as "Golden Rule", as follows:

WHEREAS, Lewis E. Melahn is the Director of the Department of Insurance, State of Missouri, an agency for the State of Missouri, created and established for administering and enforcing the provisions of Chapter 374, RSMo 1986; and

WHEREAS, Golden Rule is a foreign insurer licensed to transact business of insurance in the State of Missouri; and

WHEREAS, the Missouri Department of Insurance (hereinafter referred to as "the Insurance Department") conducted a market conduct examination of Golden Rule and prepared report number 1195-0589-ZNE; and

WHEREAS, the report of the market conduct examination has been reviewed by Golden Rule, correspondence with the Insurance Department has ensued, certain actions pursuant thereto have been taken by Golden Rule, informal conference have been held between the representatives of Golden Rule and the Insurance Department and many issues contained in the market conduct examination have been resolved without a forfeiture payment between the parties except those herein after numerated;

WHEREAS, the Department had made the following nine allegations and the Company has adamantly opposed and denied same, but in the interest of judicial economy and the time and expense of the parties and their

representatives the parties have agreed on a voluntary forfeiture by Golden Rule with the understanding the company has agreed to take remedial actions acceptable to the Director;

1. The company accepted seven (7) applications from a broker prior to his appointment as a broker for the company allegedly in violation of Sections 375.012(4) and 375.022.1, RSMo 1986, as specified on pages 2 and 3 of the market conduct examination.

2. The company failed to notify the Director of the termination of ten (10) brokers within ten (10) working days of their terminations allegedly in violation in Section 375.022, RSMo 1986, as specified on page 3 of the market conduct examination report.

3. The company paid commissions to one agency without having a current copy of the agency license on file allegedly in violation of Section 375.158.3, RSMo 1986, as specified on page 12 of the market conduct examination report.

4. The company used various ad mats that either failed to disclose the company's name or contained a rating of the company without disclosing the source of the rating allegedly in violation of 4 CSR 190-14.020(12)(A) and 4 CSR 190-14.040(15) as specified on pages 12 and 13 of the market conduct examination.

5. The company failed to adequately maintain records of the dissemination of its advertising materials, whether directly or indirectly placed before the public by the insurer, allegedly in violation of Regulations 4 CSR 190-14.040(16)(A) and 4 CSR 190-13.020(3)(A) and Section 385.936(4), RSMo 1986, as specified on page 14 of the market conduct examination report.

6. The company had sixteen (16) basic advertising sales brochures for accident and health that allegedly did not contain an accurate statement as to Missouri suicide provisions allegedly in violation of Regulation 4 CSR 190-13.110 and 4 CSR 190-13.020(4)(B) as specified on page 14 and 15 of the market conduct examination.

7. The company allegedly failed to accurately pay group major medical claims allegedly in violation of Section 375.936(11)(b), RSMo 1986, as specified on pages 68 and 69 of the market conduct examination report.

8. The company allegedly failed to accurately place policies into extended term and reduced paid-up status allegedly resulting in violations of

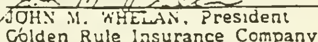
Section 375.936(11)(a), RSMo 1986, as specified on page 74 and 75 of the market conduct examination report.

9. The company allegedly issued to 341 group certificate holders certificates containing antiquated provisions and definitions no longer in compliance with existing statutes and regulations and/or provisions allegedly not in compliance with various then existing regulations and statutes.

WHEREAS, the undersigned Director of the Missouri Department of Insurance believes that in view of the foregoing a voluntary forfeiture in the amount of Seven Thousand Five Hundred Dollars ($7,500) by Golden Rule will suffice to ensure the future compliance by the company with the insurance statutes and regulations of the state of Missouri; and

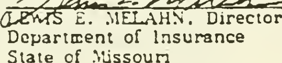
NOW, THEREFORE, in lieu of the institution by the undersigned Director of any action for the suspension or revocation of the Certificate of Authority of Golden Rule to transact the business of insurance in the State of Missouri, and after being advised by counsel, Golden Rule, does hereby voluntarily and knowingly surrender and forfeit the sum of Seven Thousand Five Hundred Dollars ($7,500), such sum to be paid into the Missouri State School Fund.

DATED: 12/27/91

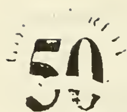


JOHN M. WHELAN, President
Golden Rule Insurance Company

DATED: 12/31/91



LEWIS E. MELAHN, Director
Department of Insurance
State of Missouri



Golden Rule

RECEIVED

SEP 04 1990

DEP'T. OF ECONOMIC DEVELOPMENT
MO. DIVISION OF INSURANCE

Lewis Melahn
Director of Insurance
Division of Insurance
State of Missouri
301 West High Street 6 North
P.O. Box 690
Jefferson City, MO 65102-0690

August 30, 1990

Dear Mr. Melahn:

This is a comment on your letter of July 3, 1990, which you wrote in response to Mr. Dickinson's letter to the Missouri Division of Insurance dated April 25, 1990.

My response: Yes, it is correct that "Golden Rule has continued to assert an adversary posture" in dealing with the Missouri Division of Insurance.

The reason for our adversarial posture is we believe the Missouri Division of Insurance has enough ill will toward Golden Rule that the Division would do us in if it could be done without public scrutiny.

- o The 1984 examination report contained numerous derogatory comments unsupported by the facts. For example, the report wrongly stated that our rescissions had been "excessive." In fact, out of approximately 13,000 policies, only 106 had been rescinded, and after the examination, only one of those was determined to have been rescinded in error.

- o In spite of the previous Director's acknowledgment that the comment about excessive rescissions was wrong, the Division refused to either clean up the report and make it factual or to keep the report confidential. The court eventually found this to be the prerogative of the Division; but from the standpoint of Golden Rule, the refusal to either correct or keep the report confidential reflected a negative bias toward our company.

- Much more relevant today is the 1989 examination. In the course of the examination, we requested that the Division agree to the confidentiality of our underwriting manual. The Division would not agree and began steps to revoke Golden Rule's license over the underwriting manual issue.

The issue of the underwriting manual was resolved because the St. Louis Business Journal wrote an editorial criticizing the Division's handling of the situation. When the editorial appeared, there was an abrupt change in the Division's behavior. There is no doubt in our minds that the Division would have gone ahead and revoked our license if it could have been done without public scrutiny.

The situation is analogous to police abuse. In the early 1970s, there was a university study of police abuse. The study involved the use of observers who travelled with the police over a period of time. Their observations were that there was significant police abuse, mostly directed at the segment of society that is least powerful, and the abuse was most likely to occur when out of public view.

I cite the police study because of the analogy to Golden Rule. The Division of Insurance has broad discretionary police power. In view of the Division's demonstrated inclination to do us harm, we keep our defenses up (i.e., "adversary posture"), and we preserve the access to public scrutiny. The readiness to revoke our license over the underwriting manual tells us the Division would do us mortal harm if there were no concern about public scrutiny.

- As far as we know, the 1989 examination of Golden Rule was the longest and most expensive on record. (Missouri's charges were three times more than any other state.) It appears that the Missouri Division of Insurance never did a similar exam on Transit Casualty, which surely needed it.

The evidence seems clear that the Missouri Division of Insurance has not been doing a very good job in exercising its oversight responsibility, with very severe consequences to the public. The potential $1 billion loss on Transit Casualty in Missouri hurts taxpayers all over the nation, for assessments to the guaranteed funds can be deducted from state premium taxes.

The Missouri Division of Insurance has not used its discretionary powers to protect the public. It has, as is often the case, used its powers to foster the likes and dislikes of the regulators.

That is not unusual when there is great discretionary power. It's easy for great power to go to one's head.

Commissioner George Fabe of Ohio told me two weeks ago that "some regulators let their position go to their head." He went on to say that a company "should be able to call you a son of a xxxxx without fear of reprisals" -- a strong statement by Commissioner Fabe. In Missouri, such action would result in the revocation of our privilege.

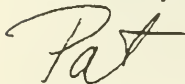
Those of us who are Christians should be able to follow the model of Jesus. Quaker theologian Elton Trueblood says what was so unusual about Jesus was he did not use power to abuse others. Trueblood observe that in those days, the abuse of power was the rule: when people came to power, they lorded it over others.

Jesus was put to death, not for his miracles, but for his criticism of those in power. If Jesus was forthright and critical of those who abused their positions of authority, we should be willing to follow that example. For us to do so is risky, because state insurance departments have a great deal of discretionary power and are apt to engage in reprisals if they don't like our criticism. We have experienced the reprisals.

We have an interest in effective regulation, for public confidence is at stake. Jane Bryant Quinn and many others have observed the increased numbers of insurance company failures and have reasonably questioned the effectiveness of state regulation.

I would be happy to meet with you to discuss the situation. Most of what has happened to Golden Rule in Missouri took place before you became insurance commissioner.

Would you suggest a date, and I'll be glad to come to talk with you.



J. Patrick Rooney
Chairman of the Board

JPR/clw

McGaughey & McGaughey
Attorneys at Law

This was done not for the citizens of Missouri, but with the full knowledge that Golden Rule had to pay for any Market Conduct Examinations, whether warranted to unwarranted.

Clearly the actions of your Department caused Golden Rule to spend a lot of unnecessary time and money resulting in a lot of bitterness which did not need to happen.

Additionally, the Missouri Market Conduct Examination lasted much too long, was far too expensive, and resulted in numerous incorrect and needlessly defamatory observations or findings.

This exercise of the Missouri Department of Insurance was akin to, "You hold 'em and I'll hit 'em" being nothing more than an attempted back alley beating of Golden Rule through the exercise of simultaneous, concerted Market Conduct Examinations.

It is this type of activity which transformed a legitimate exercise by your Department into an abusive, illegitimate exercise.

Clearly, the Missouri Insurance Department is accountable for its past acts, so I would implore you to treat Golden Rule fairly, courteously, and absent selective prosecutorial, ongoing, internal predispositions within your Department.

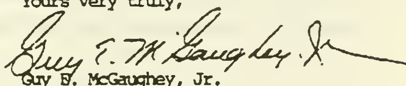
Surely your Department can be better directed and, as the class person I perceive you to be, hopefully you will accomplish this result in the future.

This letter is being written as a personal note to an individual whom I have a lot of respect for. It is not being written in any representative capacity of Golden Rule.

It takes a lot more energy to frown than smile.

With warm personal regards, I am

Yours very truly,



Guy E. McGaughey, Jr.

GEM:lls

cc: James P. Dalton
cc: J. Patrick Rooney
cc: Jack Whelan
cc: Indy West
cc: Chrono

The NAIC actuarial task force proposes new rules for individual health insurance. *They include:*

- Higher Required Loss Ratios
- Limits on commissions

Companies can only meet higher loss ratios by lowering agent compensation.

There are already adequate regulations governing individual health insurance. But the insurance department actuaries wish to make new social policy.

There are other onerous rules that would force most companies out of the market.

Agents and brokers should object.

Legislators should decide social policies--not regulatory actuaries. The people have elected legislators. The people did not elect the insurance department actuaries.

If you wish to have more information about these new social proposals, write to us:

Golden Rule®

Golden Rule Insurance Company
Golden Rule Building
Lawrenceville, Illinois 62439

Circle 19 on *RSVP* Card

6A Charleston Daily Mail★ TUESDAY ■ DECEMBER 10, 1991

Insurance firm leaves checks for lawmakers

THE ASSOCIATED PRESS

Some legislators who returned to the Capitol for a special session found surprises on their desks — unsolicited campaign contributions from an insurance company.

The money, in $100 checks, was from Golden Rule Financial Corp. Political Action Committee, the political arm of the Golden Rule Insurance Co. of Indianapolis.

Suzy Katt, vice president for government relations at Golden Rule, said the checks were supposed to have been mailed to legislators' homes.

"We tried to send as many as we possibly could to home addresses," Katt said today. "Apparently the secretary — I suspect what happened is the secretary couldn't find all the addresses and sent some to the Legislature."

She said 32 lawmakers were sent checks. Most were for $100, although a few were for $200 or $250, she said.

House Speaker Chuck Chambers questioned the propriety of leaving checks inside the House chamber.

Chambers, D-Cabell, said the checks were placed on members' desks without the knowledge of legislative officials, violating an informal rule that all mail for delegates be funneled through Sergeant-at-Arms Oce Smith.

Smith said Monday he knew nothing about the checks.

Several House members, including Chambers, said they did not receive the campaign contributions.

"Certainly, we don't want any campaign offers made in the House," Chambers said.

Mary Ratliff, deputy secretary of state, said the method of distributing the contributions sends a bad message.

"From a personal view, it does give a rather dramatic appearance as attempting to influence their legislative action," she said.

In a letter accompanying the checks, Golden Rule lobbyist Angela Sipe said the money was for re-election campaigns.

The letter said previous lobbyists Carol Warder and Suzy Katt "were impressed with you and your colleagues legislative ability."

"Consequently, Carol and Suzy have recommended that Golden Rule be supportive of you and your campaign for re-election," Sipe's letter said. "I have enclosed a check to help in this effort."

Katt said she does not know how many checks were sent to the Legislature or how they showed up on lawmakers' desks.

"We have no legislative agenda this year," Katt said. "We specifically wanted them delivered before the session because we did not want the appearance of arriving during the session, which is exactly why they arrived now."

Rick Alker, executive director of the state Ethics Commission, said the state ethics act does not apply to campaign contributions.

Ratliff said the contributions can be accepted only by candidates who have formed precandidacy financial committees, or who have unpaid debts from a previous campaign and still have campaign committees.

Leaving $100 checks on desks improper, House speaker says

By Mark Paxton

THE ASSOCIATED PRESS

The House of Delegates speaker and a deputy secretary of state expressed concern Monday after an insurance company distributed unsolicited campaign contributions inside the House chamber.

The money came from Golden Rule Financial Corp. Political Action Committee, the political arm of the Golden Rule Insurance Co. of Indianapolis.

House Speaker Chuck Chambers questioned the propriety of leaving checks for legislators on their desks inside the chamber.

"Certainly, we don't want any campaign offers made in the House," Chambers said.

Mary Ratliff, deputy secretary of state, said the method of contributing sends a bad message.

"From a personal view, it does give a rather dramatic appearance as attempting to influence their legislative action," she said.

Golden Rule lobbyist Angela Sipe wrote in a letter accompanying the checks that the money is to be used for re-election campaigns.

The letter accompanying the $100 checks said previous lobbyists Carol Warder and Suzy Katt "were impressed with you and your colleagues' legislative ability."

"Consequently, Carol and Suzy have recommended that Golden Rule be supportive of you and your campaign for re-election," Sipe's letter said. "I have enclosed a check to help in this effort."

Sipe did not return telephone calls seeking comment.

Chambers, D-Cabell, said the checks were placed on members' desks in the House chamber without the knowledge of legislative

(Please turn to Page 3B, col. 1)

Leaving gifts called improper

(Continued from Page 1B)

officials, violating an informal rule that all mail to be left on delegates' desks be funneled through Sergeant at Arms Oce Smith.

Smith said Monday he knew nothing about the letters or checks.

Several House members, including Chambers, said they did not receive the campaign contributions.

Ratliff said the contributions can be accepted only by candidates who have formed precandidacy financial committees, or who have unpaid debts from a previous campaign and still have their campaign committees.

Rick Alker, executive director of the state Ethics Commission, said the state ethics act does not apply to campaign contributions.

"We have no ability to look at campaign contributions," he said.

Secretary's mistake left checks with legislators

By Mark Paxton
THE ASSOCIATED PRESS

An insurance company secretary's mistake apparently led to some lawmakers receiving campaign contributions at their legislative desks, a company official said Tuesday.

The distribution of some checks inside the House of Delegates chamber prompted concern from some state officials.

The money came from Golden Rule Financial Corp. Political Action Committee, the political arm of the Golden Rule Insurance Co. of Indianapolis.

Suzy Katt, vice president for government relations at Golden Rule, said the checks were supposed to have been mailed to legislators' homes.

"We tried to send as many as we possibly could to home addresses," Katt said Tuesday. "Apparently the secretary — I suspect what happened is the secretary couldn't find all the addresses and sent some to the Legislature."

She said 32 lawmakers were sent checks. Most were for $100, although a few were for $200 or $250, she said.

House Speaker Chuck Chambers and Deputy Secretary of State Mary Ratliff questioned the propriety of leaving checks inside the House chamber.

In a letter accompanying the checks, Golden Rule lobbyist Angela Sipe said the money was for re-election campaigns.

Katt said she does not know how many checks were sent to the Legislature or how they showed up on lawmakers' desks.

"I certainly wish I did know," Katt said.

Katt said the Golden Rule PAC decided to contribute to the legislators in August, and she did not know a special session would begin last Friday.

"We have no legislative agenda this year," Katt said. "We specifically wanted them delivered before the session because we did not want the appearance of arriving during the session, which is exactly why they arrived now."

Mr. DINGELL. The Chair wants to welcome our first panel.

Ladies and gentlemen, I am sure you are aware that it is the practice of the committee that all witnesses testify under oath.

Do any of you object to testifying under oath? Very well.

The Chair advises that since you will be testifying under oath, it is the right of all parties who do so to be advised by counsel.

Do any of you desire to be advised by counsel during your appearance here? Very well.

The Chair advises that copies of the Rules of the House, the Rules of the Committee House, and Rules of the Subcommittee are there at the witness table before you to advise you of your rights and the limitations on the powers of the committee as you appear here before us.

With that, ladies and gentlemen, if you would please rise and raise your right hand.

[Witnesses sworn.]

Mr. DINGELL. You may each consider yourself under oath.

The Chair advises that we will hear from the panel in this order. First, Mr. Van Cooper, then Mr. Foley, then Mr. Curiale, and finally Ms. Shaheen.

Again, the Chair reiterates the thanks of the subcommittee to you all for your presence and your assistance today. It is much appreciated.

You may proceed, Mr. Van Cooper.

TESTIMONY OF THOMAS R. VAN COOPER, DIRECTOR, INSURANCE REGULATION, DEPARTMENT OF BANKING, INSURANCE AND SECURITIES, STATE OF VERMONT; TOM FOLEY, ACTUARY, FLORIDA DEPARTMENT OF INSURANCE; SALVATORE R. CURIALE, SUPERINTENDENT OF INSURANCE, STATE OF NEW YORK; C. JEANNE SHAHEEN, NEW HAMPSHIRE STATE SENATOR

Mr. VAN COOPER. Good morning, my name is Thomas Van Cooper, I am the Director of Insurance Regulation for the State of Vermont.

I want to thank you, Mr. Chairman and Members of the subcommittee, for the opportunity to discuss Vermont's health insurance reforms, in particular the requirements that health insurers use community rating and guarantee acceptance of all applicants in the small group market which is 1 to 49 employees in the State of Vermont.

Oh, I am sorry. I can start again.

Mr. DINGELL. There is one thing you are going to find out as we all learn in this room, we have the worst imaginable loudspeaker and public address system here you will ever find anywhere. Mr. Curiale has been before us before, he well remembers the difficulty we share here when he appeared on this matter.

Mr. VAN COOPER. I will try again.

Mr. DINGELL. You may proceed.

Thank you, sir.

Mr. VAN COOPER. Good morning. My name is Thomas Van Cooper, I am Director of Insurance Regulation for the State of Vermont.

I want to thank you, Mr. Chairman, and Members of the subcommittee for the opportunity to discuss Vermont's health insurance reforms, in particular the requirements that health insurers use community rating and that they guarantee acceptance of all applicants in the small group market, which is 1 to 49 employees, as of July 1, 1992, and the individual market as of July 1, 1993.

I understand that the committee is interested in Golden Rule Insurance Company. Many of the issues surrounding Golden Rule, both its conduct and its positions on health insurance, can probably be best addressed by reviewing more generally the issues Vermont faced in its individual and small group markets.

The fundamental problem that Vermont reforms address is access to health insurance. The risk selection and risk pricing practices of the commercial insurance industry had the unacceptable result of making health insurance either unavailable or unaffordable for Vermonters when they needed it the most when they were sick, injured, or aging.

Vermont's reforms have required insurers to return to the business of insurance as opposed to the business of risk avoidance. Vermont's reforms were hotly opposed by much of the health insurance industry, in particular Health Insurance Association of America and Golden Rule Insurance Company. Opponents predicted dramatic rate increases and mass withdrawal of insurers from Vermont as a result of mandating the use of community rating and guaranteed acceptance.

In fact, Vermont's reforms have been an unqualified success. Today Vermont has dynamic and competitive markets with attractive prices and products. In addition, as a result of these reforms, all Vermonters enjoy access to any of the carriers doing business in these markets without discrimination based on their age or health status and have the assurance that they will not be subject to unfair rate increases merely because they had the misfortune of needing to use the coverage they purchased for that very possibility.

Before I continue, let me review some terms that are commonly used but not always in the same way. The most important term is "insurance." "Insurance" is a social mechanism for the transfer of risk from one party to another. The party that assumes the risk, the insurer, spreads the assumed risk by pooling it through similar agreements with other insureds. "Insurance" is the spreading of risk over a broad population.

"Underwriting" is the process by which insurers select and price risk. "Community rating" means charging all members of a defined community the same premium for the same coverage for a given period. Community rating can be "pure," with no difference in price structure among insurers, or it can be "modified," in which case some price modification is permitted. The effect of community rating is to compress rates within a community.

Let me set the stage for reform in Vermont. In the mid to late 1980's, the Vermont Insurance Department became aware of problems in the small group and individual health insurance marketplaces. From the consumer's perspective, the problems can best be described as instability and unpredictability.

Consumers were finding that the availability and pricing of health insurance varied dramatically depending on their age and health status. Some commercial insurers were becoming much more sophisticated and aggressive about identifying high-risk individuals or groups and refusing to insure them or if they were already insured, either terminating them or rating them so aggressively so as to encourage them to drop coverage.

The use of policy exclusions to limit coverage became more common. So for the employer or the individual, the ability to purchase this essential product was threatened. The impact of selective underwriting also began to threaten Vermont's health insurance market.

Vermont's Blue Cross and Blue Shield plan has always used pure community rating and has guaranteed acceptance of all applicants. A problem arose when some commercial insurers began aggressively underwriting so as to only insure younger and healthier individuals, the so-called "cherry-picking" process, while Blue Cross and Blue Shield of Vermont was left insuring an older and sicker population.

Such a risk selection process quickly can reach a critical level and result in the so-called "death spiral," leading to the eventual insolvency of the company that is selected against. It did not take the Vermont Insurance Department long to recognize that absent some sort of intervention addressing the impact of selective underwriting, Vermont would no longer have an insurer of last resort and there would be no market available for those Vermonters who needed the coverage the most: the sick, the injured, and the aged.

A good illustration of the power of underwriting and the problems that arise as a result of "cherry-picking" are the loss ratios in Vermont's individual marketplace. A loss ratio is the ratio of claims paid to premiums earned. For example, if an insurer earned $1 in a premium—excuse me, $1 in premium and paid out 50 cents in claims, the insurer has a 50 percent loss ratio.

From 1986 to 1990, the average loss ratio for commercial insurers in Vermont was 52 percent. Golden Rule's lost ratio was 42.6 percent. Blue Cross and Blue Shield of Vermont's loss ratio, on the other hand, was 112 percent, and if we exclude Medicare supplement coverage, that loss ratio rises to 141 percent.

When roughly 20 percent of the population constitute 80 percent of the claims, the impact of selective underwriting can be dramatic. These loss ratios also show that risk avoidance is a very profitable business. Vermont considered a number of solutions to deal with the polarization of risk that resulted from selective underwriting, including establishing a risk pool for the uninsurable, allowing Blue Cross and Blue Shield of Vermont to begin underwriting like commercial insurers, and subsidizing high-risk individuals.

The problem with these type of solutions is that they involve the direct or indirect use of public money to cover the so-called uninsurable. Moreover, any solution that permitted commercial insurers to profit from good risks and left taxpayers paying for poor risks was unacceptable.

In view of the social purposes of insurance, the protection of consumers against loss, the cross-subsidization among insureds, and the spreading of risk among large number of insureds, a simpler

market-based solution was proposed which did not require public funds. Vermont legislature chose to require community rating guaranteed issuance, leveling the playing field among insurers so that risk could be more fairly spread among the entire marketplace as well as within each insurer's own business. Insurers must now operate in Vermont by insuring both good risks and poor risks.

Let me briefly summarize the Vermont laws that accomplish these goals in the small group and individual marketplace. Act 52, passed in 1991, requires all insurers in the small group market to community rate and to guarantee acceptance of any applicant.

The law provides for pure community rating. However, it also permits the commissioner of insurance to allow commercial insurers to deviate from the community rating by plus or minus 20 percent, which he has allowed. The amount of deviation is based on the demographics, the age and sex, of the insured group or individual.

Under Act 52 insurers are required to guarantee acceptance of all applicants. Insurers are prohibited from using individual exclusions to limit coverage for a particular illness or condition. In addition, they are only permitted to use a preexisting condition limitation for 12 months. This limitation must be waived, however, if coverage existed during the prior 9 months.

Act 160, passed in 1992, provides almost identical requirements in the individual market as those in the small group market, except that the commissioner may permit a deviation from a community rate of plus or minus 40 percent until July 1, 1995, and plus or minus 20 percent thereafter, the purpose of which I will explain shortly. Commercial insurers have been permitted to use a 40 percent deviation, using demographics to set the amount of deviation.

Finally, a unique program called the "safety-net" was instituted. This program was created partly in response to a threat by Golden Rule to withdraw from Vermont if community rating and guaranteed issuance was required in the individual market. Under this program, any individual or employer whose insurer withdrew from Vermont is entitled to comparable coverage at comparable prices from Blue Cross and Blue Shield of Vermont.

As I said earlier, Vermont's reforms have been very successful. Looking at Vermont's experience, I believe the issue is not whether community rating and guaranteed acceptance are good social policy. They are a clear benefit to consumers, and they do not have any downside.

The issue is, however, how to transition from markets that have been selectively underwritten to markets that are not selectively underwritten. Community rating has the effect of compressing rates. Under community rating, some of those who have paid less because they were a preferable risk will pay more, and those who have paid more because they are undesirable will pay less than they previously paid.

To oversimplify, it has the effect of pushing rates to the middle. Both Golden Rule and the Health Insurance Association of America argued that community rating would result in dramatic rate increases for younger groups and individuals, and that as a result these groups and individuals would suffer rate shock and simply withdraw from the market altogether.

In recognition that the underwriting practices of commercial insurers had possibly skewed pricing in the market severely, thereby creating tremendous price differences in the market between the highest and lowest premiums, the department proposed the deviations from the community rate of which I spoke earlier. These deviations have served a useful transition tool by allowing a more gradual compression of rates.

The deviations, together with the safety-net program, allow for a transition to community rating that had minimal disruption to employers or individuals. Equally important, Vermont's health insurance prices have remained low. There has not been the increase in aggregate prices that opponents of community rating had insisted would occur.

During the 1992 legislative session, Golden Rule circulated a memorandum from its actuarial department that projected rate increases of 302.9 percent for those in the youngest age bracket and even 16.9 percent increase for those in the oldest age bracket as a result of community rating. In fact, no such increases have occurred.

Let me briefly review some actual rate changes that resulted from community rating: Time Insurance Company's insureds in the individual market in the youngest age bracket experienced a rate increase of 6.6 percent, while insureds in the oldest age bracket experienced a 37.7 percent rate decrease.

I note that the largest increase for Time's insureds was in the 30 to 34 age bracket, who saw a 24.2 percent rate increase. Similarly, in the small group market, Time Insurance Company's insureds in the youngest age bracket experienced a 20.2 percent increase, while those insureds in the oldest age bracket saw 36.9 percent decrease.

Guardian Life Insurance Company's insureds in the small group market experienced a range of rate activity from 8.8 percent increases to 51 percent decreases. This is not to say that the Department of Insurance did not get calls from upset consumers regarding price increases.

While no study has been conducted of Vermont's reactions to these reform proposals, I believe the vast majority of Vermonters approve of these changes. Moreover, there is no data to suggest that younger and healthier Vermonters have withdrawn from the marketplace as a result of these reform measures. Most employers and individuals who had benefited under the old underwriting practices, accepted higher prices in exchange for a stable and rational marketplace.

The young and healthy, previously enjoying lower rates, recognized that it is just a matter of time before they fall into the undesirable category of a commercial insurer. "There but for the grace of God go I."

Another argument that opponents had raised against Vermont's reform was that no insurer could do business in a community-rated, guaranteed issue market, that insurers would be unable to control their experience, that there would be no way to adequately forecast future claim costs. Not true. When all insurers are competing on a level playing field, there is no reason why a stable market

cannot exist and why a fair profit cannot be made. Just ask the 17 carriers competing in Vermont right now.

Did insurers leave the State as a result of these reforms? Sure, some chose to leave, including Golden Rule. However, other insurers took their place, recognizing the opportunity to do business and make a fair profit in Vermont.

Today Vermont has 17 carriers competing in the small group market, and eight carriers in the individual market. Now, that may not sound like a lot, but Vermont only has 560,000 citizens, and in fact, we now have more carriers actively competing for business than before these reform measures. More significantly, we now have much more capacity since every one of these carriers will take all comers.

In sum, Vermont's reforms have been a success. The consumer can have confidence in a stable and rational marketplace in which coverage is guaranteed and available at a fair price. In fact, prices are low and competition among insurers for business is high.

During the legislative debate the Health Insurance Association of America and Golden Rule rolled out their actuaries and experts to explain why the reforms would not work, but rather than fall prey to the numbers game in which one actuary battles another, we relied on common sense and looked to the definition of insurance for guidance. Insurance is not about risk avoidance, it is about the pooling of risk.

Let me discuss briefly Golden Rule and its practices in Vermont. Before discussing Golden Rule's behavior in Vermont, I want to state that the company did not violate any Vermont laws by its conduct. I believe that its underwriting practices, however, were instrumental in creating the support that led to the passage of reform legislation in Vermont that rendered its type of underwriting illegal.

What are the tools of the aggressive underwriter? The first is the initial application form filled out by a consumer. I have attached a copy of the Golden Rule form to my testimony.

Let me briefly review its scope. Item 15 of the application asks for information about health status over a 10-year period. The questions asked are very broad and refer to any disorder that the applicant may have had. How many of us have not had a headache or diarrhea or a bad stomachache over the past 10 years?

Another tool used more extensively by Golden Rule than other insurers is the exclusion. This is a limitation placed on the policy to exclude coverage for a particular individual, condition, disease, et cetera.

When Golden Rule withdrew from Vermont, most of its insureds elected to become members of Blue Cross and Blue Shield of Vermont under the safety-net program I discussed earlier. As a result, the safety-net program allows unique access to information about Golden Rule policies.

Of the approximately 5,000 Golden Rule policyholders who joined the safety net, approximately 25 percent of them had some type of exclusion under their Golden Rule policies. In an initial study done by Blue Cross and Blue Shield of Vermont, 1024 Golden Rule policyholders had 1245 separate exclusions added to their policies. I have attached some examples of these policy exclusions.

Subscriber B applied for health insurance from Golden Rule on September 18, 1991. The subscriber had been treated by a physician in June 1991 for bumps on his skin that were determined to be fatty deposits of no concern. Golden Rule excluded any loss incurred resulting from any form of tumor or tumorous growth, including complications therefrom or operation therefor.

Subscriber C, treated with aspiration for fluid in a benign cyst located in breasts, Golden Rule excluded any loss incurred resulting from any disease or disorder of the breast, including complications therefor.

Subscriber F applied for health insurance from Golden Rule on January 15, 1992. The subscriber, a self-employed commercial painting contractor, indicated no experience with back problems. Golden Rule excluded any loss incurred resulting from any injury to disease or disorder of the spinal column, including vertebrae, intervertebral disks, spinal cord, nerves, surrounding ligaments and muscles, including complications therefrom or operations therefor.

Blue Cross and Blue Shield of Vermont also compiled a list of more than 81 exclusions used by Golden Rule. These include the exclusions of whole body parts, such as arms, backs, breasts, hips, knees, legs, hands, skin, testes and so on. I think the list speaks for itself.

A particularly disturbing practice with Golden Rule was to selectively underwrite newborn children of individuals holding individual rather than family policies. After providing the 30-day coverage of newborn children mandated by Vermont law, Golden Rule would only extend coverage if the newborn was healthy.

In sum, community rating and guarantee issuance represent good social policy, good insurance policy and good business policy. The Vermont Legislature quickly saw through the self-interested doomsday prophecies of the commercial insurance industry about radical price increases and the destruction of Vermont's insurance market and instead recognized there is no reason insurers could not make a fair profit, play on a level playing field where they could compete on the quality of service they provided and the management of costs rather than the avoidance of risk. Vermont consumers need no longer worry about whether they will be able to have access to this essential product.

Thank you.

[The prepared statement of Mr. Van Cooper follows:]

OFFICE OF THE COMMISSIONER

STATE OF VERMONT
DEPARTMENT OF BANKING, INSURANCE AND SECURITIES

MEMORANDUM

TO: John D. Dingell, Chairman
Subcommittee on Oversight and Investigations

FROM: Thomas R. Van Cooper
Director of Insurance Regulation

DATE: June 27, 1994

SUBJECT: Vermont Health Care Reform Initiatives

Introduction

Good morning. My name is Thomas Van Cooper. I am the Director of Insurance Regulation for the state of Vermont. I want to thank you, Mr. Chairman and members of the subcommittee, for the opportunity to discuss Vermont's health insurance reforms. In particular, the requirements that health insurers use community rating and that they guarantee acceptance of all applicants, in the small group (1-49 employees) market as of July 1, 1992, and in the individual market as of July 1, 1993. I understand that the committee is interested in Golden Rule Insurance Company. Many of the issues surrounding Golden Rule, regarding both its conduct and its positions on health insurance, can probably be best addressed by reviewing more generally the issues Vermont faced in its individual and small group markets.

An important finance issue that Vermont confronted in its effort to obtain health care reform involved the impact of insurers employing aggressive underwriting techniques that either explicitly excluded some Vermonters from the marketplace or effectively did so by pricing such individuals out of the marketplace. The cost of care for individuals forced out of the marketplace is borne by other taxpayers and insureds, whether through tax based social programs or by less easily identified shifts of uninsured and underinsured costs to the private insurance marketplace. Since Vermont had a social contract to provide health care to all citizens regardless of their ability to pay, it needed a fair insurance mechanism for financing health care.

The fundamental problem that Vermont's reforms address is access to health insurance. The risk selection and risk pricing practices of the commercial insurance industry had the unacceptable result of making health insurance either unavailable or unaffordable for Vermonters when they

needed it the most: when they were sick, injured or aging. Vermont's reforms have required insurers to return to the business of insurance, as opposed to the business of risk avoidance.

Vermont's reform efforts were hotly opposed by much of the health insurance industry, in particular Health Insurance Association of America and Golden Rule Insurance Company. Opponents predicted dramatic rate increases and mass withdrawal of insurers from Vermont as a result of mandating the use of community rating and guaranteed acceptance. See Attachment A.

In fact, Vermont's reforms have been an unqualified success. Today, Vermont has dynamic and competitive markets with attractive prices and products. In addition, as a result of these reforms, all Vermonters enjoy access to any of the carriers doing business in these markets without discrimination based on their age or health status and have the assurance that they will not be subject to unfair rate increases merely because they have the misfortune of needing to use the coverage they purchased for that very possibility.

Definitions

Before I continue, let me review some terms that are commonly used, but not always in the same way. The most important term is "insurance." Insurance is a social mechanism for the transfer of risk from one party to another. The party that assumes the risk, the insurer, spreads the assumed risk by pooling it through similar agreements with other insureds. Insurance is the spreading of risk over a broad population. "Underwriting" is the process by which insurers select and price risk. "Community rating" means charging all members of a defined community the same premium rate for the same coverage for a given period. Community rating can be "pure," with no difference in price structure among insureds, or it can be "modified," in which case some price variation is permitted. The effect of community rating is to compress rates within a community. I note that the benefits of community rating, the pooling and cross subsidization of risk, are diminished if communities are permitted to be defined too narrowly, such as the community of young and healthy.

Setting the stage

In the mid-to-late 1980s the Vermont insurance department became aware of problems in the small group and individual health insurance marketplaces. From the consumer's perspective the problems can best be summarized as instability and unpredictability. Consumers were finding that the availability and pricing of health insurance varied dramatically depending on their age and health status. Some commercial insurers were becoming much more sophisticated and aggressive about identifying high risk individuals or groups and refusing to insure them, or if they were already insured, either terminating them or rating them so aggressively as to encourage them to drop coverage. The use of policy exclusions to limit coverage became more common. So for the employer, or the individual, the ability to purchase this essential coverage was threatened.

The impact of selective underwriting also began to threaten Vermont's health insurance market. Vermont's Blue Cross and Blue Shield plan has always used pure

community rating and has guaranteed acceptance of all applicants. A problem arose when some commercial insurers began aggressively underwriting so as to insure only younger and healthier individuals ("cherry picking"), while Blue Cross and Blue Shield of Vermont was left insuring an older and sicker population. Such a risk selection process quickly can reach a critical level and result in the so-called death spiral, leading to the eventual insolvency of the company that is selected against. A death spiral occurs when an insurer is selected against and must raise its prices to cover the higher claims cost of its sicker and older insureds, then upon raising its prices loses what is left of its healthier business. This cycle repeats itself until there is an uninsurable risk pool, and premiums cannot cover claims. Unless the cycle is broken, the insurer's insolvency is only a matter of time. It did not take the Vermont insurance department long to recognize that, absent some sort of intervention addressing the impact of selective underwriting, Vermont would no longer have an insurer of last resort and there would be no market available for those Vermonters who needed the coverage the most: the sick, injured and aged.

A good illustration of the power of underwriting and the problems that arise as a result of "cherry-picking" are the loss ratios in Vermont's individual marketplace. A loss ratio is the ratio of claims paid to premiums earned. For example, if an insurer earned one dollar in premium and paid out 50 cents in claims, the insurer has a 50 percent loss ratio. From 1986 to 1990 the average loss ratio for commercial insurers was 52 percent. Golden Rule's loss ratio was 42.6 percent. Blue Cross and Blue Shield of Vermont's loss ratio, on the other hand, was 112 percent. (Excluding Medicare supplement policies, from 1986 to 1990 Blue Cross and Blue Shield's loss ratio was 141 percent.) When roughly 20 percent of the population constitute 80 percent of the claims, the impact of selective underwriting can be dramatic. Loss ratios also show that risk avoidance is a very profitable business practice.

Vermont considered a number of solutions to deal with the polarization of risk that resulted from selective underwriting, including establishing a risk pool for the uninsurable, allowing Blue Cross and Blue Shield of Vermont to begin underwriting like commercial insurers, and subsidizing high risk individuals. The problem with these types of solutions is that they involved the direct or indirect use of public money to cover the so-called uninsurable. Moreover, any solution that permitted commercial insurers to profit from good risks and left taxpayers paying for poor risks was unacceptable. In view of the social purpose of insurance: 1) the protection of consumers against loss, 2) the cross-subsidization among insureds, and 3) the spreading of risk across large numbers of insureds, a simpler, market-based solution was proposed that did not require public funds.

Act 52 and Act 160 Overview

The Vermont Legislature chose to require community rating and guaranteed issuance, leveling the playing field among insurers so that risk would be more fairly spread over the entire marketplace, as well as within each insurer's own business. Insurers must now operate in Vermont by insuring both good risks and poor risks.

Let me briefly summarize the Vermont laws that accomplished these goals in the small group and individual markets. Act 52, passed in 1991, requires all insurers in the small group market to community rate, to guarantee acceptance of any applicant and to offer common benefit plans. The law provides for pure community rating; however it also permits the commissioner of insurance to allow commercial insurers to deviate from the community rate by plus or minus 20 percent, which she has allowed. The amount of deviation is based on the demographics of the insured group or individual.

Under Act 52, insurers are required to guarantee acceptance of all applicants. Insurers are prohibited from using individual exclusions to limit coverage for a particular illness or condition. In addition, they are only permitted to use a pre-existing condition limitation for twelve months. This limitation must be waived, however, if coverage existed during the prior nine months. Some limitation must be allowed to ensure that groups do not select against insurers by only buying coverage when it is needed, and this limited pre-existing period suffices. However, once a group has been insured for nine months, they have absolute portability and can switch among the insurers in the marketplace without penalty.

Act 52 also requires that one or more common benefit plans be offered by all insurers so as to permit consumers to do an apples-to-apples comparison of insurer prices. I have attached a copy of the common benefit plan for your consideration. See Attachment B.

Act 160, passed in 1992, provides almost identical requirements in the individual market as those in the small group market, except that the Commissioner may permit a deviation from a community rate of plus or minus 40 percent until July 1, 1995, and plus or minus 20 percent thereafter, the purpose of which I will explain shortly. Commercial insurers have been permitted to use a 40 percent deviation, using demographics to set the amount of deviation.

Finally, a unique program called the safety-net was instituted. This program was created partly in response to a threat by Golden Rule to withdraw from Vermont if community rating and guaranteed issuance was required in the individual market. Under this program, any individual or employee whose insurer withdrew from Vermont was entitled to receive comparable coverage at comparable prices from Blue Cross and Blue Shield of Vermont.

Summary of Vermont's experience

As I said earlier, Vermont's reforms have been very successful. Looking at Vermont's experience, I believe the issue is not whether community rating and guaranteed acceptance are good social policy. They benefit consumers and do not have any downside. The issue is, however, how to transition from markets that have been selectively underwritten to markets that are not selectively underwritten. Community rating has the effect of compressing rates. Under community rating some of those who have paid less because they are a preferable risk will pay more, and those who have paid more because they are undesirable will pay less than they previously paid. To oversimplify, it has the effect of pushing rates to the middle.

Both Golden Rule and Health Insurance Association of America argued that community rating would result in dramatic rate increases for younger groups and individuals, and that, as a result, these groups and individuals would suffer "rate-shock" and simply withdraw from the market altogether. In recognition that the underwriting practices of commercial insurers had possibly skewed pricing in the market severely, thereby creating tremendous price differences between the highest and lowest premiums, the department proposed the deviations from the community rate of which I spoke earlier. These deviations have served as a useful transition tool by allowing for a more gradual compression of rates. The deviations, together with the safety-net program, allowed for a transition to community rating that had minimal disruption to employers or individuals.

Equally important, Vermont's health insurance prices have remained low. There has not been the increase in aggregate prices that opponents of community rating had insisted would occur. During the 1992 legislative session, Golden Rule circulated a memorandum from its actuarial department that projected rate increases of 302.9 percent for those in the youngest age bracket and even a 16.9 percent increase for those in the oldest age bracket as a result of community rating. See Attachment C. In fact, no such increases have occurred. Let me briefly review some actual rate changes that resulted from community rating. Time Insurance Company insureds in the individual market in the youngest age bracket experienced a rate increase of 6.6 percent while insureds in the oldest age bracket experienced a 37.7 percent rate decrease. (The largest increase was for insureds in the age 30-34 bracket who experienced a 24.2 percent rate increase.) Similarly, in the small group market Time Insurance Company's insureds in the youngest age bracket experienced a 20.2 percent increase while those insureds in the oldest age bracket saw a 36.9 percent decrease. Guardian Life Insurance Company's insureds in the small group market experience a range of rate activity from 8.8 percent increases to 51 percent decreases.

This is not to say that the department of insurance did not get calls from upset consumers regarding price increases. While no study has been conducted of Vermonters' reactions to these reform proposals, I believe the vast majority of Vermonters approve of these changes. Moreover, there is no data to suggest that younger and healthier Vermonters have withdrawn from the marketplace as a result of these reform measures. Most employers and individuals who had benefitted under the old underwriting practices accepted higher costs in exchange for a stable and rational marketplace. The groups or individuals that are young and healthy today will at some point become older and less healthy. The young and healthy, previously enjoying lower rates, recognized that it is just a matter of time before they fall into the "undesirable" category of a commercial insurer. There, but for the grace of God, go I.

Another argument that opponents had raised against Vermont's reform was that no insurer could do business in a community rated, guaranteed issue market; that insurers would be unable to control their experience; that there would be no way to adequately forecast future claims and price. Not true. When all insurers are competing on a level playing field, there is no reason why a fair profit cannot be made. Just ask the 17 carriers competing in Vermont right now.

Did insurers leave the state as a result of the reforms? Sure, some chose to leave, including Golden Rule. However, other insurers took their place, recognizing the opportunity to do business and make a fair profit in Vermont. Today Vermont has 17 carriers competing in the small group market and 8 carriers in the individual market. Now that may not sound like a lot, but Vermont only has 560,000 citizens and in fact, we now have more carriers actively competing for business than before the reform measures. More significantly, we now have much more capacity, since every one of these carriers will take all comers. I have attached a list of the companies doing business and some of the prices for products they are selling. See Attachment D.

In sum, the reforms in Vermont have been a success. The consumer can have confidence in a stable and rational marketplace in which coverage is guaranteed and available at a fair price. In fact, prices are low, and competition among insurers for business is high. During the legislative debate, the HIAA and Golden Rule rolled out their actuaries and experts to explain why the reforms would not work. But rather than fall prey to the numbers game in which one actuary battles another, we relied on common sense and looked to the definition of insurance for guidance. Insurance is not about risk avoidance. It is about the pooling of risk.

Golden Rule

Before discussing Golden Rule and its behavior in Vermont, I want to state that the company did not violate any Vermont laws by its conduct. I believe that its underwriting practices, however, were instrumental in creating the support that led to the passage of reform legislation in Vermont that rendered its type of underwriting illegal.

What are the tools of an aggressive underwriter? The first is the initial application form filled out by a consumer. I have attached a copy of a Golden Rule form. See Attachment E. Let me briefly review its scope. Item 15 of the application asks for information about health status over a ten-year period. The questions asked are very broad and refer to any disorder that the applicant may have had. How many of us have not had a headache or diarrhea or a bad stomach ache over the past ten years?

Another tool used more extensively by Golden Rule than by other insurers is the exclusion. This is a limitation placed on the policy to exclude coverage for a particular individual, condition, disease, etc. When Golden Rule withdrew from Vermont, most of its insureds elected to become members of Blue Cross and Blue Shield of Vermont under the safety-net program I discussed earlier. As a result, the safety-net program allows unique access to information about Golden Rule policies.

Of the approximately 5,000 Vermont Golden Rule coverage policyholders who joined the safety-net, approximately 25 percent of them had some type of exclusion under their Golden Rule policies. In an initial study done by Blue Cross and Blue Shield, 1,024 Golden Rule policyholders had 1,245 separate exclusions added to their policies. I have attached some examples of these policy exclusions. See Attachment F. I will review a few of them.

> Subscriber B applied for health insurance from Golden Rule on September 18, 1991. The subscriber had been treated by a physician in June of 1991 for bumps on the skin that were determined to be fatty deposits of no concern. Golden Rule excluded any loss incurred resulting from any form of tumor or tumorous growth, including complications therefrom or operation therefor. The exclusion was in force at the time Golden Rule terminated coverage on November 1, 1992.

> Subscriber C also treated with aspiration of fluid in benign cysts located in breasts. Golden Rule excluded any loss incurred resulting from any disease or disorder of the breasts, including complications therefor. This included any reconstructive surgery or complications of reconstructive surgery. The exclusion was in force at the time Golden Rule terminated coverage on July 19, 1993.

> Subscriber F applied for health insurance from Golden Rule on January 15, 1992. The subscriber, a self-employed commercial painting contractor, indicated no experience with back problems. Golden Rule excluded any loss incurred resulting from any injury to, disease or disorder of the spinal column, including vertebrae, intervertebral discs, spinal cord, nerves, surrounding ligaments and muscles, including complications therefrom or operation therefor. The exclusion was in force at the time Golden Rule terminated coverage on March 1, 1993.

Blue Cross and Blue Shield also compiled a list of more than 81 exclusions used by Golden Rule. These include the exclusion of whole body parts, such as arms, backs, breasts, hips, knees, legs, hands, skin, testes and so on. I think the list speaks for itself. See Attachment G.

A particularly disturbing practice of Golden Rule was to selectively underwrite newborn children of individuals holding individual rather than family policies. After providing the 30 day coverage of newborn children mandated by Vermont law, Golden Rule would only extend coverage if the newborn was healthy.

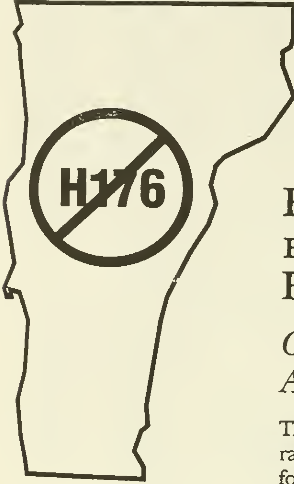
Summary

Community rating and guarantee issuance represent good social policy, good insurance policy and good business policy. The Vermont legislature quickly saw through the self-interested doomsday prophesies of the commercial industry about radical price increases and the destruction of Vermont's insurance market, and instead recognized that there was no reason insurers could not make a fair profit playing on a level playing field, where they could compete on the quality of service they provided and the management of costs rather than the avoidance of risk. Vermont consumers need no longer worry about whether they will be able to have access to this essential product.

THE TIMES ARGUS BARRE-MONTPELIER, VT SATURDAY MAY 4 1991

ATTACHMENT A

Political Advertisement Political Advertisement Political Advertisement Political Advertisement Political Advertisement Political Advertisement



Higher Premiums for Your Health Coverage

Or No Health Coverage At All

That's what H 176, the "community rating" or "Blues Bailout" bill, will do for you. And it's already passed the Vermont General Assembly.

Community rating means that every insurance company must charge the same rate to all its small business customers. The result: Some employers will be paying over 50 percent more than they are now. Some will drop their health insurance completely. And you — or someone you know — will be left without health insurance coverage.

Why did your state legislators vote to increase your health insurance premiums?

Because a group of powerful lobbyists for Blue Cross and Blue Shield of Vermont want it that way.

They get a bailout and you get the bill.

But you can stop them. Call Governor Dick Snelling at (802) 828-3333 and tell him not to sign this bill into law.

Your health may depend on it.

HIAA

Health Insurance Association of America

The Burlington Free Press — Wednesday, July 1, 1992

Of ferrets, weasels and health care

Insurance company hires lawyers to protect its clients

By Betsy Liley
Free Press Staff Writer

MONTPELIER — The Golden Rule Insurance Co. has hired two Montpelier lawyers to ensure their 11,000 Vermont policyholders are protected by provisions included in a new law.

The health care reform bill passed this year prohibits health insurers from basing rates on health and age. That provision, known as community rating, led to Golden Rule's pulling out of the state.

The health bill guarantees that policyholders will receive comparable insurance coverage at no more than 15 percent more than what they now pay.

Saying they didn't want the state "to weasel out" of the protections, Golden Rule President J. Patrick Rooney said, "We're here to see that guarantee is kept."

Rooney brought two ferrets labeled "The Gov" and "The Commish" for Gov. Howard Dean and Banking and Insurance Commissioner Jeffrey Johnson, who pushed through the health reforms. The animals were meant as stand-ins for weasels, which the state classifies as wildlife and cannot be used as pets.

At what became a rowdy, confrontational news conference in front of the Statehouse, Rooney called the health insurance provision "essentially socialism" because it makes old and young Vermonters pay the same rates.

"We used to do community rating. We finally stopped because it was so unfair," Rooney said.

During the news conference, two men stood behind Rooney holding anti-Golden Rule signs. One, held by Chris Wood, read: "Golden Rule No. 1: Thou shalt rip off Vermont consumers. Golden Rule No. 2: If you can't rip off Vermonters, thou shalt weasel their way out."

Ted Cote, sporting a Gropper for Senate button, pushed Wood repeatedly through the news conference, trying to nudge him away from Rooney. "I didn't think it was very polite for him during a press conference to crowd the president of a large company," Cote said.

Wood is a board member of the Vermont Consumers Campaign for Health.

Later, Dean spokesman Glenn Gershaneck, state Sen. Cheryl Rivers, D-Windsor, and a Golden Rule agent from Rutland, Michael Moser, got into a heated argument surrounded by the media.

"There are a lot of reasons why people are picking on health insurers," Gershaneck said. "If health insurance was working we wouldn't be where we are."

"I think the way the governor characterized it (Golden Rule's departure) last week still stands. It seems like sour grapes," he said. "I think it's kind of a silly way to deal with a serious issue."

Gershaneck and Johnson said Vermont hoped to ensure universal coverage by spreading the risk among a greater pool of policyholders. "I think the issue of risk-spreading is now front and center in Vermont," Gershaneck said.

Moser said Golden Rule had a right to leave the state.

KAREN PIKE RIESNER, *Free Press*

J. Patrick Rooney, president of Golden Rule Insurance Co. (left), and attorney Darrell Richey speak on the Statehouse steps Tuesday. Behind them, Chris Wood of Vermont Consumers Campaign for Health, protests against Golden Rule.

Chris Gee/Times Argus

Officials of the Golden Rule Insurance Co. set up a display to protest Vermont's new health reform law on the tate House walkway Tuesday.

Golden Rule Offers Objections

Insurance Company Protests Health Care Reform Law

By ROSS SNEYD
The Associated Press

MONTPELIER — Golden Rule Insurance Co. isn't leaving Vermont quietly.

Executives of the insurance company, which did battle with the Legislature over insurance reforms, even brought two ferrets to a news conference Tuesday to drive homs opposition to community rating for individual policy holders, the change that prompted the company's departure.

Community rating, which takes effect July 1, 1993, requires an insurer to provide coverage for all who apply regardless of their medical histories.

Golden Rule Chairman J. Patrick Rooney said he does not think his former customers will get a good deal from the state, even though the new law calls for the state to find comparable coverage at rates no more than 15 percent higher than customers' current premiums.

The Dean administration rejected Golden Rule's objections as nothing but sour grapes by a company unwilling to participate in health-care reform.

"We brought the animals along because we want to say it's very important that the state of Vermont not be able to weasel out of the provisions of the law," Rooney said.

Golden Rule wanted to display two weasels, one dubbed "The Gov" and the other named "The Commish," to parody Gov. Howard Dean and Insurance Commissioner Jeffrey Johnson. It settled for ferrets because Vermont law considers weasels wildlife and prohibits them from being used as pets.

Rooney said younger, healthier people will be forced to pay higher rates for insurance premiums to subsidize insurance for older people who pose a greater risk to an insurer.

"It's taking from the people who are least able to pay premiums to cover people are most able to pay," he said.

Johnson conceded that younger people will pay more for coverage now, but their premiums will not rise as dramatically as they age. "You pay more at 25 but the result will be at 45 you'll still be able to afford it," he said.

Even critics of the Dean's go-slow approach to health-care reform turned out to protest Golden Rule's tactics. While Rooney spoke, a pair of protesters representing the Vermont Consumers' Campaign for Health stood behind him hoisting signs denouncing Golden Rule.

One sign said: "Golden Rule No. 1 — Thou shalt rip off Vermont consumers. Golden Rule No. 2 — If thou can't rip off Vermonters, thou shalt weasel their way out."

"It's clear that Golden Rule is just trying to scare Vermonters away from this dramatic change," said Chris Wood, one of the protesters.

Dean spokesman Glenn Gershaneck, who watched Rooney's news conference from the sidelines, agreed. "I think the way the governor characterized it last week still stands. It seems like sour grapes," he said. "I think it's kind of a silly way to deal with a serious issue."

Gershaneck and Johnson said Vermont hoped to ensure universal coverage by spreading the risk among a greater pool of policyholders. "I think the issue of risk-spreading is now front and center in Vermont," Gershaneck said.

Rooney said community rating was the wrong approach to universal access. Creating a comprehensive insurance pool, into which all insurers would pay, would be better, he said.

Burlington Free Press
6/30/92
page 4c

Golden Rule chairman to demonstrate at Statehouse

By Tom Hacker
Free Press Staff Writer

The head of an Indiana insurance company that has pulled out of Vermont in protest of the state's health care reform package will use live animal props in a demonstration on the Vermont Statehouse steps today.

J. Patrick Rooney, chairman of the Golden Rule Insurance Co., will appear at 11:30 a.m. with two "weasel-like rodents," said company spokeswoman Suzy Katt, one nicknamed "The Gov," the other "The Commish."

"Rooney will explain how these varmints may try to weasel their way out of the tight corner they're in, and how Golden Rule plans to protect its former policyholders if they try," Katt said in a statement Monday.

Golden Rule made good last week on a threat to cease doing business in Vermont if the Legislature approved a health care reform package containing new restrictions on the way insurance providers can operate in the state.

The company, which specializes in covering individuals who do not participate in employer-provided insurance programs, has about 6,000 health insurance policies in effect in Vermont, said Shawn W. Bryan, deputy commissioner for insurance at the state Banking, Insurance and Securities Department.

Bryan said a state "safety net" included in the new health care bill protects Golden Rule policy holders by allowing them to convert their coverage to Blue Cross and Blue Shield of Vermont at comparable rates. The law allows for a 15 percent annual increase in premiums to account for inflation.

Bryan said Golden Rule has blocked the state from doing all it can for policyholders by refusing to share insurance records for comparison purposes. "We have made every effort to work with the company to get the information we need so that we can assist these people," he said. "If I have to, I'll subpoena it."

Gov. Howard Dean said last week he saw the departure of Golden Rule as a good sign, not a signal that health insurance structures were breaking down under the new law as the company claimed.

Dean and other state officials said that Golden Rule, by providing coverage only to the young and healthy, was reaping huge profits by cutting risk factors. State Banking Commissioner Jeffrey Johnson called the Golden Rule practice "a recipe for making money."

Golden Rule officials have said the state is trying to avoid its responsibility to the company's policyholders by forcing them into more costly insurance programs.

Katt said Rooney will announce today the hiring of public interest lawyers to represent former Golden Rule policyholders, and "make sure the state doesn't weasel out of the governor's legislative guarantee" that comparable coverage be provided at no more than 15 percent added cost.

Bryan said that while the law provides for a 15 percent cap on increases, any added premiums for Golden Rule policyholders would be "somewhat less than that."

ATTACHMENT B

ACT 52 INSURANCE PLAN I

OUTLINE OF COVERAGE

POLICY NUMBER	- 999-99-9999	**EMPLOYEE NAME AND ADDRESS**
MEMBERSHIP TYPE	- 1P/2P/FAMILY	JOHN J. DOE
PREMIUM PAYMENT	-	APARTMENT 15-B
GROUP NUMBER/NAME	- 12345-678	19 MAPLE AVENUE
	COMMON INDUSTRY, INC.	MANAGED CARE, VT 05699-1234

THE MAXIMUM YOU MUST PAY TOWARD:

ANNUAL DEDUCTIBLE

INDIVIDUAL	- $ 150
TWO-PERSON	- $ 300
FAMILY	- $ 450

OUT-OF-POCKET LIMIT

INDIVIDUAL	- $ 500
TWO-PERSON	- $1,000
FAMILY	- $1,500

COVERAGE IS SUBJECT TO THE FOLLOWING INDIVIDUAL BENEFIT MAXIMUMS:

COMPREHENSIVE CERTIFICATE

LIFETIME . . . . - $1,000,000 /LIFETIME

TRANSPLANT AGGREGATE . . . . . . - $1,000,000 /LIFETIME

MENTAL HEALTH - INPATIENT . . . - 45 /DAYS/YEAR PAYABLE AT 80%

- OUTPATIENT . . - 40 /VISITS/YEAR PAYABLE AT 80%

YOUR PORTION OF COVERED CHARGES FOR COVERED SERVICES

	COINSURANCE	
AMBULANCE	20%	
*CARDIAC REHABILITATION	20%	
*DENTAL	20%	
*DIAGNOSTIC	20%	
*GENERAL HOSPITAL	20%	
*HOME CARE	20%	
*HOSPICE CARE	20%	
*MATERNITY	20%	
PRE-NATAL CARE	0%	- SEE PREVENTIVE CARE
*MEDICAL EQUIPMENT/SUPPLIES	20%	
*MEDICAL CARE	20%	
*MENTAL HEALTH		
INPATIENT	20%	
OUTPATIENT (40 VISITS)	20%	
*PHYSICAL REHAB FACILITY	20%	
PRESCRIPTION DRUGS	20%	
PREVENTIVE CARE	0%	- UP TO $150, THEN 20% THEREAFTER
*SKILLED NURSING FACILITY	20%	
*SUBSTANCE ABUSE REHAB FACILITY	20%	
*SURGICAL	20%	
*THERAPY	20%	
*TRANSPLANTS	20%	

DEDUCTIBLES APPLY TO ALL SERVICES EXCEPT FOR PREVENTIVE CARE
SEE ARTICLE III FOR COVERED SERVICES

* YOU MUST RECEIVE **ADMISSION REVIEW OR PRIOR APPROVAL** FROM US FOR SPECIFIC SERVICES AS DEFINED IN YOUR POLICY OR LISTED ON THIS OUTLINE OF COVERAGE.

ACT 52 INSURANCE PLAN II

OUTLINE OF COVERAGE

POLICY NUMBER	- 999-99-9999	**EMPLOYEE NAME AND ADDRESS**
MEMBERSHIP TYPE	- 1P/2P/FAMILY	JOHN J. DOE
PREMIUM PAYMENT	-	APARTMENT 15-B
GROUP NUMBER/NAME	- 12345-678	19 MAPLE AVENUE
COMMON INDUSTRY, INC.		MANAGED CARE, VT 05699-1234

THE MAXIMUM YOU MUST PAY TOWARD:

ANNUAL DEDUCTIBLE

INDIVIDUAL	- $ 500
TWO-PERSON	- $ 1000
FAMILY	- $ 1500

OUT-OF-POCKET LIMIT

INDIVIDUAL	- $1,000
TWO-PERSON	- $2,000
FAMILY	- $3,000

COVERAGE IS SUBJECT TO THE FOLLOWING INDIVIDUAL BENEFIT MAXIMUMS:

COMPREHENSIVE CERTIFICATE

LIFETIME	- $1,000,000 /LIFETIME
TRANSPLANT AGGREGATE	- $1,000,000 /LIFETIME
MENTAL HEALTH - INPATIENT . . .	- 45 /DAYS/YEAR PAYABLE AT 80%
- OUTPATIENT . . .	- 40 /VISITS/YEAR PAYABLE AT 80%

YOUR PORTION OF COVERED CHARGES FOR COVERED SERVICES

	COINSURANCE	
AMBULANCE	20%	
*CARDIAC REHABILITATION	20%	
*DENTAL	20%	
*DIAGNOSTIC	20%	
*GENERAL HOSPITAL	20%	
*HOME CARE	20%	
*HOSPICE CARE	20%	
*MATERNITY	20%	
PRE-NATAL CARE	0%	- SEE PREVENTIVE CARE
*MEDICAL EQUIPMENT/SUPPLIES	20%	
*MEDICAL CARE	20%	
*MENTAL HEALTH		
INPATIENT (45 DAYS/YEAR)	20%	
OUTPATIENT (40 VISITS/YEAR)	20%	
*PHYSICAL REHAB FACILITY	20%	
PRESCRIPTION DRUGS	20%	
PREVENTIVE CARE	0%	- UP TO $150, THEN 20% THEREAFTER
*SKILLED NURSING FACILITY	20%	
*SUBSTANCE ABUSE REHAB FACILITY	20%	
*SURGICAL	20%	
*THERAPY	20%	
*TRANSPLANTS	20%	

DEDUCTIBLES APPLY TO ALL SERVICES EXCEPT FOR PREVENTIVE CARE
SEE ARTICLE III FOR COVERED SERVICES

* YOU MUST RECEIVE **ADMISSION REVIEW OR PRIOR APPROVAL** FROM US FOR SPECIFIC SERVICES AS DEFINED IN YOUR POLICY OR LISTED ON THIS OUTLINE OF COVERAGE.

VERMONT
ACT 52 INSURANCE PLAN

TABLE OF CONTENTS

Article	Title	Page
I	DEFINITIONS	2
II	MANAGED BENEFIT PROGRAM	
	Program Goals	8
	Program Requirements	8
	Benefit Reduction for Non-Compliance	8
III	COVERED SERVICES	
	Ambulance	9
	Cardiac Rehabilitation	9
	Dental	9
	Diagnostic	10
	General Hospital	10
	Home Care	11
	Hospice Care	11
	Maternity	12
	Medical Equipment/Supplies	12
	Medical Care	13
	Mental Health	13
	Physical Rehabilitation Facility	14
	Prescription Drugs	14
	Preventive Care	14
	Skilled Nursing Facility	14
	Substance Abuse Rehabilitation Facility	15
	Surgical	15
	Therapy	16
	Transplants	17
IV	EXCLUSIONS	18

ARTICLE I
DEFINITIONS

The following terms have special meanings in this contract. The usage of these terms is very important for you to clearly understand this contract. These terms are not capitalized in this contract for ease of reading. Words used often in this contract are defined in this article. Other words are defined where used in the text.

ACUTE CARE treats illnesses, injuries or conditions marked by a sudden onset or abrupt change of status requiring prompt medical attention. Acute care may include hospitalization of limited duration. Acute care produces measurable improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time.

ADMISSION REVIEW is our determination of whether your unscheduled inpatient admission is medically necessary for:
- an emergency condition;
- a maternity condition; or
- a condition requiring an extended hospital stay of a newborn.

ANESTHESIA—the administration of anesthetics to obtain:
- general or regional (but not local) muscular relaxation;
- loss of sensation; or
- loss of consciousness.

ASSISTANT SURGEON is a physician or physician's assistant (PA) who actively assists the operating surgeon in performing surgery.

ATTENDING PHYSICIAN is the physician responsible for your overall care and direction of treatment.

BENEFIT is the amount we pay for a service as shown on your explanation of benefits.

BIRTHING CENTER is an alternative birthing facility with a certified nurse midwife or physician providing care.

CHILD is a covered employee's:
- unmarried son, daughter or stepchild;
- legally adopted child (including a child living with the adoptive parents during the period of probation); or
- child for whom the covered employee is legal guardian.

A child must live in the covered employee's household unless (s)he is a full-time dependent student. A child must be under 19 years of age or a full-time dependent student under 25 years of age.

CHRONIC CARE treats an illness, injury or condition that does not require hospitalization. Chronic care may:
- require confinement in an alternative facility (i.e. nursing home);
- be expected to be of long duration without any reasonably predictable date of termination; and
- be marked by reoccurrences requiring acute care on a continuous or periodic basis.

COINSURANCE is the amount you must pay after you meet your deductible for services shown on your outline of coverage.

COMMUNITY MENTAL HEALTH FACILITY provides mental health services. Examples of these facilities include:
- hospitals;
- outpatient psychiatric clinics;
- day treatment centers; and
- community mental health centers.

A community mental health facility must be approved by the Secretary of the Agency of Human Services.

CONSULTATION is a review by a professional provider whom your attending physician asks to give professional advice about your condition.

CONTINUED STAY REVIEW is our review to determine if your continued hospitalization is medically necessary.

CONTRACT consists of:
- the documents listed on your outline of coverage;
- your identification card; and
- your application and any supplemental applications submitted by you and approved by us.

CO-PAYMENT is the fixed dollar amount you must pay for specific services, if any, as shown on your outline of coverage.

COSMETIC SURGERY is surgery primarily intended to improve appearance.

COVERED EMPLOYEE is the individual with whom we have entered into this contract or on whose behalf the group has entered into this contract.

COVERED SERVICE is a service or supply eligible for benefits under this contract.

CUSTODIAL CARE is primarily for maintenance or designed to help in your daily living activities. Custodial care is not primarily provided for its medical value. Custodial care includes, but is not limited to:
- help in walking, bathing, dressing and feeding;
- preparation of special diets;
- supervision over administration of medications; and
- care not requiring skilled nursing services.

DEDUCTIBLE is the amount you must pay toward the cost of specific services before we pay any benefits. Deductible amounts are shown on your outline of coverage.

DEPENDENT is a covered employee's spouse or child covered under this contract.

DURABLE MEDICAL EQUIPMENT (DME) is equipment:
- prescribed by your physician;
- primarily and customarily used only for a medical purpose;
- appropriate for use in the home;
- designed for prolonged and repeated use; and
- not generally useful to a person without illness or injury.

DME includes, but is not limited to: wheelchairs, hospital-type beds, walkers, traction equipment and respirators.

DME does not include items such as: air conditioners, dehumidifiers, whirlpool baths, exercise equipment and other equipment that has both non-medical and medical uses.

EMERGENCY ACCIDENT CARE is emergency treatment of traumatic bodily injuries resulting from an accident.

EMERGENCY MEDICAL CARE is emergency services provided after the sudden onset of a medical condition. The patient must exhibit acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to:

- place the patient's health in serious jeopardy;
- cause serious impairment to bodily functions; or
- cause serious dysfunction of any bodily organ.

EXPERIMENTAL or INVESTIGATIONAL (DRUG, DEVICE AND MEDICAL TREATMENT OR PROCEDURE): a drug, device or medical treatment or procedure is experimental or investigational :

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- if the drug, device, treatment or procedure, or the patient informed consent document utilized with the drug, the device, treatment or procedure, was reviewed and approved by the treating facilities' Institutional Review Board or other body serving similar function, or if federal law requires such review and approval; or
- if reliable evidence shows that the drug, device or medical treatment or procedure is the subject of on-going phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
- if reliable evidence shows that the prevailing opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device or medical treatment or procedure.

FACILITY PROVIDER is one of the following institutions or entities:

- Ambulatory Surgical Center
- Birthing Center
- General Hospital
- Home Health Agency/Visiting Nurse Association/Private Duty Nurse
- Physical Rehabilitation Facility
- Skilled Nursing Facility
- Substance Abuse Rehabilitation Facility
- Psychiatric Hospital
  - Facilities further defined in this article.

GENERAL HOSPITAL is a short-term, acute care hospital that:

- is a duly licensed institution;
- primarily provides diagnostic and therapeutic services for the diagnosis, treatment and care of injured and sick persons by or under the supervision of physicians;
- has organized departments of medicine and major surgery; and
- provides 24-hour nursing service by or under the supervision of registered nurses.

GROUP is an individual, firm, association or corporation that has agreed to forward to us or through a remitting agent premiums due under this contract.

HOME HEALTH AGENCY/VISITING NURSE ASSOCIATION is an organization that brings skilled nursing and other services into your home. It must be certified under Title 18 of the Social Security Act, as amended.

INDEPENDENT CLINICAL LABORATORY performs clinical procedures and is not associated with a facility or professional provider.

INDIVIDUAL CASE BENEFIT MANAGEMENT is our review to determine if an alternative setting or treatment would be appropriate for

your condition. We provide benefits for alternative settings or treatment even if we do not cover them under this contract. Our decision to provide benefits for alternative care in one case shall not obligate us to provide the same benefits again to you or any other person covered under this contract.

INPATIENT is a patient at a facility provider for whom the facility charges room and board. We compute the length of an inpatient stay by counting either the day of admission or discharge, but not both.

MEDICAL CARE is care by a professional provider for treatment of an illness or injury.

MEDICALLY NECESSARY (MEDICAL NECESSITY) is our determination of whether services or supplies are:

- appropriate for the symptoms, diagnosis or treatment of your condition, illness, disease or injury;
- provided for the diagnosis or direct care and treatment of your condition, illness, disease or injury;
- in accordance with standards of good medical practice;
- not primarily for your or your provider's convenience; and
- the most appropriate supply or level of service that can safely be provided to you.

Even though a provider prescribes, perfarms, orders, recommends or approves a service, this does not connote medical necessity. The final determination of medical necessity rests with us.

MEDICAL/SURGICAL SUPPLIES include, but are not limited to: syringes, dressings, catheters, colostomy bags and oxygen. These supplies are used for medical purposes only.

OUTLINE OF COVERAGE is a summary of your contract benefits.

OUT-OF-POCKET LIMIT(S) is the maximum amount of deductibles plus coinsurance you must pay during a calendar year. After you have satisfied your out-of-pocket limit, you are no longer required to pay coinsurance during the remainder of that calendar year.

OUTPATIENT is any setting where you receive services or supplies while not an inpatient.

PHYSICAL REHABILITATION FACILITY primarily provides rehabilitation care services on an inpatient basis. Care consists of the combined use of medical, social, educational and vocational services. These services enable patients disabled by disease or injury to achieve continued improvement of functional ability. Services must be provided by or under the supervision of physicians. Nursing services must be provided under the supervision of registered nurses.

PHYSICIAN is a doctor of medicine, dental surgery, medical dentistry or osteopathy.

PRE-ADMISSION REVIEW is our review to determine if your scheduled inpatient admission is medically necessary.

PRE-EXISTING CONDITION is a condition for which:

- medical advice or treatment was recommended by or received from a professional provider within a one year period preceding your continuous coverage with us, or
- the existence of symptoms that would cause a prudent person to seek diagnosis, care or treatment within a one year period preceding your continuous coverage with us.

Benefits for pre-existing conditions will be paid after a person has been insured under this plan for 12 months in a row.

> **EXCEPTIONS** - Pre existing conditions will be waived for all new employees or members, and their dependents, who produce evidence of continuous health benefit coverage during the previous nine months substantially equivalent to this plan.

PRIOR APPROVAL is the required written approval that you must obtain from us before you receive specific services noted in this contract. **If you do not obtain written approval from us before you receive services, benefits may be reduced.**

PROFESSIONAL PROVIDER is a practitioner only as listed:
- Audiologist
- Certified Substance Abuse Counselor
- Independent Clinical Laboratory
- Mental Health Professionals:
  - Clinical Psychologist
  - Clinical Social Worker
  - Clinical Mental Health Counselor
  - Psychiatric Nurse Practitioner
- Nurses:
  - Certified Registered Nurse Anesthetist (CRNA)
  - Licensed Practical Nurse (LPN)
  - Nurse Practitioner
  - Nurse Midwife (CNM)
  - Registered Nurse (RN)
- Optometrists
- Physician (including Dentists and Psychiatrists)
- Podiatrist
- Therapists (Occupational, Physical and Speech)

PROVIDER is a facility provider, professional provider or other provider:
- approved by us;
- licensed and/or certified where required; and
- acting within the scope of that license and/or certification.

PSYCHIATRIC HOSPITAL provides diagnostic and therapeutic facilities for the diagnosis, treatment and acute care of mental and personality disorders. Care must be directed by a staff of physicians. A psychiatric hospital must:
- provide 24-hour nursing service by or under the supervision of registered nurses (RN);
- keep permanent medical history records; and
- be a private psychiatric or public mental hospital approved by the Secretary of the Agency of Human Services.

RECONSTRUCTIVE SURGERY corrects deformities resulting from birth, injury or disease, or that are medically necessary following injury or disease.

SKILLED NURSING FACILITY primarily provides inpatient skilled nursing care and related services. Care requires 24-hour skilled nursing services but does not require confinement in a general hospital. Physicians provide or direct services. Facilities must keep permanent medical history records. The facility is not, other than occasionally, a place that provides:
- minimal care, custodial care, ambulatory care, or part-time care services;
- care or treatment of mental illness, substance abuse or pulmonary tuberculosis; or
- rehabilitation.

SPOUSE is the covered employee's spouse under a legally valid marriage between persons of the opposite sex.

SUBSTANCE ABUSE is any use of alcohol or drugs that produces a pattern of behavior causing:
- impairment in social or occupational functioning; or
- physiological dependency evidenced by physical tolerance or withdrawal.

SUBSTANCE ABUSE REHABILITATION FACILITY primarily provides rehabilitation treatment for substance abuse. Treatment must follow a written plan. Facilities must be approved by the Secretary of the Agency of Human Services.

SURGERY is a generally accepted invasive, operative and cutting procedures. This includes, but is not limited to:
- specialized instrumentations;
- endoscopic examinations;
- treatment of burns; and
- correction of fractures and dislocations.

THERAPY SERVICES include, but are not limited to the following treatments:

Radiation therapy treats disease by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.

Chemotherapy prevents the development, growth, or multiplication of malignant diseases by chemical or biological agents.

Dialysis removes waste materials when a patient has acute kidney failure or chronic irreversible kidney deficiency.

Physical therapy relieves pain of an acute condition; restores function; and prevents disability following disease, injury or loss of body part.

Occupational therapy promotes the restoration of a physically disabled person's ability:

- to accomplish the ordinary tasks of daily living; and
- to accomplish the ordinary tasks required by the person's particular occupation.

Therapy uses constructive activities designed and adapted for each specific condition.

Speech therapy tries to correct speech impairment resulting from disease, surgery, injury, congenital and developmental anomalies or previous curative processes.

Infusion therapy treats disease conditions by continuous injection of curative agents. Treatment may be given by a facility provider or self-administered.

Inhalation therapy uses inhalation of medicine, water vapor and/or gases to treat impaired breathing.

TOTAL CHARGE is the total amount charged by the provider for a service.

YOU, YOUR is the covered employee and any dependents covered under this contract.

WE, US, OUR is the insurer or any designated agent(s) of the insurer.

ARTICLE II
MANAGED BENEFIT PROGRAM

PROGRAM GOALS

The goals of this program are:

- to contain health care costs;
- to provide health care services in settings that best meet your needs: and
- to acquaint you with treatment options.

In order to meet these goals, we **require you** to contact us for:

- pre-admission review: and
- admission review.

Your health care coverage may be limited if you do not comply with the requirements outlined below. Even if this coverage is secondary to other coverage available to you from another health insurance provider, you must comply with the Managed Benefit Program.

Also, in order to meet these goals, we may, at our discretion, use:

- individual case benefit management; and
- continued stay review.

PROGRAM REQUIREMENTS

Pre-admission Review---Non Emergency and Maternity Conditions

You must contact us for **prior approval** before a scheduled inpatient admission. You must also notify us if your admission or service date is changed. We recommend that you contact us two weeks before the admission or service date.

Admission Review---Emergency and Maternity Conditions

You must contact us within 48 hours (or as soon as reasonably possible) after an emergency or maternity admission. You must also contact us within 48 hours (or as soon as reasonably possible) after the mother's discharge if the newborn stays in the hospital. Note: A family member, attending physician or facility may contact us. However, it is ultimately your responsibility to ensure that notification is timely.

BENEFIT REDUCTION FOR NON-COMPLIANCE

Your benefits may be reduced if you do not meet the above program requirements as follows:

Pre-admission Review or Admission Review

You will be responsible for a portion of the inpatient charges equal to **$500.00** per admission.

ARTICLE III
COVERED SERVICES

This article explains your coverage. All benefits are subject to the exclusions, conditions and limitations cited in this contract.

Remember, you are only eligible for benefits if:
- your treatment, intervention or other service is medically necessary;
- your treatment, intervention or other service is a covered service;
- you receive services from a professional provider;
- you meet the **Managed Benefit Program** requirements, which include:

  prior approval before scheduled inpatient admissions; and

  admission review after an emergency or maternity admission;

- you obtain prior approval for services specified in this article; and
- your treatment, intervention or other service is not as a result of pre-existing condition, as defined.

AMBULANCE SERVICES

Benefits---Transportation of the sick and injured, by air or land:
- to a general hospital from your home, scene of accident or scene of medical emergency;
- between general hospitals; or
- between a general hospital and skilled nursing facility.

Requirements---The ambulance must be a specially designed and equipped vehicle for transportation of the sick and injured.

Limitations---We only provide benefits for your transportation to the closest facility that can provide services appropriate for the treatment of your condition.

Exclusions---We provide no benefits if you could have been transported in a private car.

CARDIAC REHABILITATION SERVICES

Definitions---

Cardiac rehabilitation is for a cardiac event related to an acute coronary artery disease. An acute cardiac event includes, but is not limited to:
- a myocardial infarction; or
- a coronary artery bypass graft or coronary angioplasty, resulting in maximum functional capacity at 3 weeks post-event of less than 8 METS (Metabolic Energy Equivalent).

Benefits---Supervised exercises sessions up to 3 sessions per week and up to a total of 18 sessions for each cardiac event.

Requirements---We only provide benefits if:
- a cardiac rehabilitation provider performs the services;
- you obtain prior approval; and
- your condition meets our medical eligibility requirements as we determine from time-to-time.

DENTAL SERVICES

Benefits---
- temporomandibular joint syndrome;
- accidental injury to the jaws, sound natural teeth, mouth or face occurring on or after your membership effective date;
- oral surgery required to correct gross deformity resulting from major disease or surgery;
- surgical removal of bone-impacted teeth;
- gingivectomy only for specific conditions defined by us; and
- care resulting from medical necessity.

Requirements---We require prior approval for:
- dental services resulting from accidental injury to sound natural teeth beyond six months following an accident;
- oral surgery required to correct gross deformity; and
- medically necessary dental care.

Exclusions---We provide no benefits for:
- any dental services performed by other than a physician, as defined;
- care for periodontitis;
- repair or replacement of damaged dental prosthesis;
- injury as a result of chewing or biting; and
- dental care not specified as a benefit above.

DIAGNOSTIC SERVICES

Benefits---Diagnostic services to determine a definite condition or disease, ordered by a provider, include, but are not limited to:

- imaging (radiology, ultrasound and nuclear);
- studies of the nature and cause of disease (laboratory and pathology tests);
- medical procedures (ECG and EEG); and
- allergy testing (percutaneous, intracutaneous, patch and RAST testing).

Limitations---We require prior approval for diagnostic services.

GENERAL HOSPITAL SERVICES

Benefits---General hospital services and supplies related to covered medical and surgical services include:

- inpatient room, board and general nursing services for any type of room appropriate for your care;
- outpatient surgery;
- ancillary supplies and services; and
- emergency care.

Benefits for mental health services in a general hospital are applied toward your mental health benefit maximums.

Ancillary supplies and services include, but are not limited to:

- use of operating, delivery and treatment rooms;
- prescribed drugs;
- anesthesia, anesthesia supplies and services provided by an employee of the hospital;
- medical/surgical supplies;
- diagnostic services;
- therapy services;
- laboratory services; and
- intravenous medications, (e.g., steroids, antibiotics and hemophilia agents).

Requirements---We only provide benefits for:

Inpatient facility charges if you obtain prior approval.

Emergency care if:

- treatment of injuries resulting from an accident requires emergency accident care or a medical condition requires emergency medical care; and
- emergency care commences within 72 hours of the emergency.

Exclusions---We provide no benefits for:

Additional inpatient days that we determine are not medically necessary.

Facility charges when we determine that the medical/surgical services could have been performed appropriately on an outpatient basis.

Private rooms unless your attending physician and we determine it is medically necessary.

HOME CARE

Benefits---Skilled nursing services (including private duty nursing services) of a registered or licensed practical nurse to:

- perform necessary procedures;
- train your family or other care givers in your home to perform necessary procedures; and
- perform physical, occupational and speech therapy.

We provide benefits for home health aide services (for personal care only) when you are receiving skilled nursing or therapy services up to 40 visits per year. Each visit by a member of a home health care agency, other than a home health aide, shall be considered one home health care visit, and four hours of home health aide service shall be considered one home health care visit.

Requirements---We only provide benefits if:

- you obtain **prior approval**; and
- you are under the care of a physician who:
  a. approves a plan of treatment for a reasonable time;
  b. includes the treatment plan in your medical record; and
  c. certifies that the services are for acute care (not for chronic care).

The patient, or a legally responsible individual, must consent in writing to the home health care treatment plan. The treatment plan must be approved by us and certified by your physician every 60 days.

Exclusions---We provide no benefits for dietitian services, homemaker services, maintenance therapy, custodial care or food or home delivered meals.

HOSPICE CARE

Definitions---

Hospice is an organization engaged in providing care to the terminally ill. It must be federally certified to provide hospice services or accredited as a hospice by the Joint Committee of Accreditation of Health Care Organizations.

Benefits---

Skilled nursing visits---up to 2 visits per day.

Home health aide---up to 100 hours per month for personal care services only.

Continuous care---besides respite care, you may receive up to 5 days or 120 hours for the patient's continuous care in your home.

Social service visits---up to 6 visits before the patient's death and up to 2 bereavement visits following the patient's death. Social service visits may include:

- counseling and emotional support;
- assessment of social and emotional factors related to the patient's condition;
- assistance in resolving problems;
- assessment of financial resources; and
- use of available community resources.

Respite care---up to 72 hours each month. Respite care relieves your family or care givers by providing temporary relief from the duties of caring for your terminal illness. Respite care will be provided in a general hospital or in your home, whichever is most appropriate.

Durable medical equipment.

Prescription drugs and supplies.

Requirements---We only provide benefits if:

- a physician certifies that your terminal illness has a prognosis of 6 month life expectancy or less;
- you and your physician consent to the hospice care plan; and
- a primary care giver (family member or friend) will be in the home.

MATERNITY RELATED SERVICES

Maternity---

Benefits---Facility, medical and surgical services for pre-natal care, normal and complicated pregnancies.

Requirements---You must obtain **admission review** after your inpatient admission.

If this contract terminates during your pregnancy, maternity benefits will be provided according to the contract in effect at the time of delivery if your pregnancy began while you were covered under this contract.

Exclusions---We provide no benefits for services related to pregnancy or childbirth if:

- we replace your previous insurance carrier; and
- your previous insurance carrier has extended liability.

Newhorn Care---

Benefits--Coverage shall include care for sickness, injury, necessary care and treatment of medically diagnosed congenital defect or birth abnormality, or any combination of these. Routine inpatient nursery care and examinations of your newborn is also covered.

Remember, we only provide benefits under this contract for newborns up to 31 days after birth unless notification of birth is given to us within 31 days after birth.

MEDICAL EQUIPMENT/SUPPLIES

Durable Medical Equipment

Benefits---The rental or purchase of durable medical equipment (DME).

Requirements---We only provide benefits for DME equipment costing over $500 if you obtain **prior approval**.

If we choose to purchase the durable medical equipment:

- we reserve the right to reimburse you the coinsurance and deductible amounts paid for the equipment; and
- the equipment becomes our property if we reimburse you.

Medical Surgical Supplies

Benefits---Medical surgical supplies purchased by you.

Orthotics

Benefits---Rigid or semi-rigid support devices which restrict or eliminate motion of a weak or diseased body part.

Exclusions---We provide no benefits for:

- corrective shoes which are not attached to a brace; or
- "shoe insert orthotics."

Prosthetics

Benefits---The purchase, fitting, necessary adjustments, repairs and replacements of prosthetic devices and supplies that replace:

- all or part of an absent body organ (including contiguous tissue);
- the lens of an eye. (Only one set of eyeglasses or contact lenses will be provided for the original prescription, and one set for each new prescription.); or
- all or part of the function of a permanently inoperative, absent or malfunctioning body part.

Exclusions---We provide no benefits for:

- dental appliances (except as provided under Dental Services); and
- eyeglasses or contact lenses, except when necessary to replace the lens of the eye.

MEDICAL CARE SERVICES

Benefits---

Inpatient medical care visits by a professional provider.

Outpatient home, office and other medical care visits by a professional provider include the examination, diagnosis and treatment of an injury or illness.

Outpatient hospital emergency medical or accident care.

Requirements---

Audiologist---We provide benefits for laboratory hearing tests only if your physician refers you to an audiologist when (s)he finds or reasonably suspects a disease condition or injury.

Emergency medical or accident care---We provide benefits only if care commences within 72 hours after the emergency.

Limitations---

Office visits---We limit benefits for medical care visits to one visit per day.

Exclusions---We provide no benefits for:

Inpatient or outpatient visits for conditions under this section for mental illness, surgery or maternity. These conditions are covered in other sections in this contract.

Hearing care such as hearing aids or examinations for the prescription or fitting of hearing aids.

Eye care examinations for prescribing, fitting or determining your need for eyeglasses or contact lenses. Also, we provide no benefits for:

- the correction of near- or far-sighted conditions by means of corneal microsurgery; and
- eye exercises.

MENTAL HEALTH SERVICES

Definitions---

Mental health services diagnose or treat nervous or mental conditions listed in the Mental Disorders Section in the current International Classification of Diseases Manual (ICD), except:

- conditions related to substance abuse; (refer to Substance Abuse section); and
- conditions of, including, but not limited to: hyperkinetic disorders, developmental delays, mental retardation, and psychological factors associated with diseases classified elsewhere in the ICD.

Benefits---Mental health services furnished and billed by a:

- community mental health facility;
- general or psychiatric hospital;
- physician; or
- mental health professional who is a professional provider as defined.

Inpatient and outpatient professional provider services for the treatment of mental illness include:

- individual and group psychotherapy;
- family counseling to help in diagnosing and treating the patient;
- psychological testing; and
- electroshock treatment or convulsive drug therapy. This benefit includes anesthesia when it is given for this treatment.

Limitations:

Professional Services---We limit benefits to one visit per day.

Maximum Benefits---Benefits for mental health services are limited for each calendar year as shown on your outline of coverage.

Exclusions---We provide no benefits for any mental health services:

- beyond the initial evaluation to diagnose mental deficiency or retardation;
- for mental disorders or illness that, according to generally accepted professional standards, will not improve with treatment;
- for non-health or non-medical reasons; or
- that we determine do not produce evidence of continued improvement or maximum rehabilitative potential within a reasonable and medically predictable period of time.

.SICAL REHABILITATION FACILITY SERVICES

Benefits---Inpatient treatment for an acute medical condition.

Requirements---We only provide benefits if:
- you obtain **prior approval**; and
- your attending physician refers you for treatment and obtains recertification from us every 30 days.

Exclusions---We provide no benefits for cognitive retraining and educational programs

PRESCRIPTION DRUGS

Benefits---Prescription drugs and insulin purchased by you that:
- require a physician's prescription by federal law of the United States;
- are FDA-approved; and
- we approve for the specific medical condition.

PREVENTIVE CARE SERVICES

Benefits---Outpatient office visits by a physician or nurse practitioner include, but are not limited to:
- well child care;
- eye exams;
- routine physical examinations;
- immunizations and injections;
- mammograms; and
- pre-natal care.

Limitations---

Office visits---We limit benefits for medical care visits to one visit per day.

Exclusions---We provide no benefits for:

Hearing care such as hearing aids or examinations for the prescription or fitting of hearing aids.

Eye care examinations for prescribing, fitting or determining your need for eyeglasses or contact lenses. Also, we provide no benefits for:
- the correction of near- or far-sighted conditions by means of corneal microsurgery; and
- eye exercises.

SKILLED NURSING FACILITY SERVICES

Benefits---Inpatient services include:
- room, board (including special diets) and general nursing care;
- medication and drugs; and
- nonsurgical medical services as included in the rates of a skilled nursing facility.

Requirements---We only provide benefits if you obtain **prior approval** and your condition requires acute care.

Limitations---We only provide benefits for as long as it is medically necessary for the proper treatment of the medical condition.

SUBSTANCE ABUSE REHABILITATION SERVICES

Benefits---

Detoxification---up to 5 days per occurrence.

Outpatient rehabilitation (including your family where necessary)---up to 90 hours per occurrence and up to a total of 180 hours per lifetime.

Inpatient rehabilitation---up to 28 days or day equivalents per occurrence with up to 56 days or day equivalents per person per lifetime.

A "day equivalent" is 2 partial days. A partial day means services at a substance abuse treatment facility for more than 2 but less than 24 hours.

Requirements---We only provide benefits:

- if you obtain **prior approval** for **inpatient rehabilitation**;
- for **inpatient detoxification** if your physician certifies that non-hospital detoxification is inappropriate; and
- for **inpatient rehabilitation** if your substance abuse counselor certifies that inpatient treatment is appropriate. The certifying substance abuse counselor cannot be an employee of the facility.

SURGICAL SERVICES

Benefits---

Surgery including operating surgeons, assistant surgeons, team surgeons and co-surgeons.

Special surgery including oral surgery (see Dental Services), reconstructive surgery and sterilization surgery (regardless of the medical necessity).

Anesthetists.

Requirements---We only provide benefits for reconstructive surgery if we determine that an overriding medical condition exists and you obtain **prior approval**.

Exclusions---

Pre- and post-operative care---We consider most pre- and post-operative visits part of the surgical benefit. Therefore, we do not provide additional benefits for these services.

Reverse sterilization---We provide no benefits for surgical procedures to reverse sterilization.

THERAPY SERVICES

Benefits---Therapy services for the treatment of an illness or injury include, but are not limited to:

- chemotherapy;
- dialysis treatment;
- infusion therapy;
- inhalation therapy;
- physical therapy;
- radiation therapy;
- occupational therapy. Examples of conditions where benefits may be considered include, but are not limited to:
  - a. a cerebral vascular accident;
  - b. an amputation (upper extremities);
  - c. a spinal cord injury;
  - d. burns of upper extremities; or
  - e. surgery or injury to the hand or wrist; and
- speech therapy. Examples of conditions where benefits may be considered include, but are not limited to:
  - a. removal of the larynx and pharynx;
  - b. surgery to correct congenital abnormality; or
  - c. a cerebral vascular accident.

Requirements---We only provide benefits if:

Prior Approval is obtained.

Therapy services:

- a. produce measurable improvement within a reasonable and medically predictable period of time;
- b. show measurable restorative potential and progress;
- c. are prescribed by the attending physician.
- d. are provided by or billed by a facility or professional provider; aod
- e. are prescribed by your attending physician.

Occupational therapy begina within 60 days after the date of initial care for the illness or injury.

Speech therapy begins within 60 days after the date of initial care for the illness or injury.

Limitations---

Maximum benefit---We limit your combined total of all of your occupational, physical and speech therapy sessions to a benefit of 40 sessions per calendar year.

Physical therapy---We limit benefits to 6 months after initiation of physical therapy.

Occupational therapy---We limit benefits to 6 months after the date of initial care.

Speech therapy---We limit benefits to 6 months after the date of initial care.

Exclusions---We provide no benefits for:

Speech therapy for speech loss or impairment due to:

- a. a functional nervous/psychiatric disorder;
- b. mental retardation;
- c. nonphysical conditions such as learning disabilities, stuttering, alcoholism; or
- d. developmental delays, including, but not limited to lack of normal physiological development; infantile cerebral palsy; multiple sclerosis; hyperkinetic syndrome of childhood; myoneural disorders; and hearing loss or disorder.

Pain management programs, except for physician prescribed TENS units.

TRANSPLANT SERVICES

Benefits---

Organ and bone marrow transplants include but are not limited to:

- heart;
- heart/lung:
- lung:
- liver;
- pancreas:
- allogeneic bone marrow;
- autologous bone marrow;
- cornea:
- kidney; or
- tissue.

Related transplant expenses---We provide benefits for services directly related to the search, surgical removal, storage and transportation costs for the organ, bone marrow or tissue.

Donor expenses---We provide benefits for a live donors medical expenses:

- if their human organ, bone marrow or tissue transplant is donated to a human transplant recipient;
- when only you (as the recipient) are covered by us; and
- up to the transplant lifetime maximum benefit. Benefits available to you will be paid first. Remember, benefits provided to the donor will be charged against your coverage.

When we cover both the recipient and the donor, each is entitled to the benefits of his/her contract. We provide no other benefits to a donor covered under this contract, except as described above.

Requirements---We only provide benefits if prior approval is obtained at least 72 hours before inpatient admission. We reserve the right to review all requests for prior approval based on:

- the patient's medical condition;
- the physicians' qualifications performing the transplant procedure; and
- the facilities' qualifications hosting the transplant procedure.

We use the above information to determine whether it is consistent with our criteria.

Limitations

Time period---We provide benefits for recipient expenses that are directly related to the transplant procedures for the period of time from 5 days before the procedure to 52 weeks after the procedure. Any benefits provided outside of this period of time are subject to the terms and conditions in the other sections of this contract.

Related transplant expenses---We limit benefits to $10,000 per transplant.

Lifetime maximum benefit---We limit benefits to a combined lifetime total of $1,000,000 for all transplants.

Exclusions---We provide no benefits for:

- services or supplies related to transplant procedures (artificial or human) considered investigational or experimental, as defined ;
- the purchase price of any organ or tissue that is sold rather than donated; and
- any organ transplant for which, and to the extent that, the patient or donor receives research or grant funding directly or through a provider.

ARTICLE IV
EXCLUSIONS

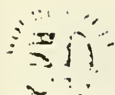
GENERAL
This contract does not provide benefits for services or supplies that:
- a prior health plan is obligated to cover as extended benefits.
- you would have no legal obligation to pay in the absence of this contract or any similar coverage.
- are not specifically listed as covered services.
- are charged
  - a. for failure to keep a scheduled visit;
  - b. for completion of a claim form; and
  - c. in excess of the limitations set forth in this contract.
- we determine are not medically necessary.
- we determine are investigative in nature.

PROVIDERS
This contract does not provide benefits for services or supplies provided by:
- a professional provider who:
  - a. is enrolled in an education or training program when such services are related to the education or training program; or
  - b. is a member of the immediate family (services only).
- a school infirmary.
- a Veterans Administration facility for a service-connected disability.
- anyone without charge or paid for directly or indirectly by a local, state or federal government agency (except Medicaid or a Veterans Administration facility in connection with a non-service-connected disability).

SERVICES AND SUPPLIES
This contract does not provide benefits for:
- acupuncture.
- automatic ambulatory blood pressure monitoring.
- biofeedback and other forms of self-care or self-help training.
- chiropractic care.
- conditions related to autistic disease of childhood, hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or for inpatient confinement for environmental change.
- contraceptives and contraceptive devices.
- cosmetic surgery.
- custodial care, domiciliary care or rest cures.
- drugs and pharmaceuticals that by federal law do not require a prescription in the United States.
- educational evaluation or therapy.
- illnesses or injuries sustained:
  - a. in the course of employment. (This exclusion does not apply to any persons for whom Workers' Compensation insurance is optional under Vermont Title 21, Section 601, and who choose not to obtain such insurance.); or
  - b. on or after the effective date of enrollment:
    - i. as a result of an act of war within the United States, its territories or possessions;
    - ii. while in active military service; or
    - iii. during combat, unless otherwise required by law.
- institutional or custodial care for the physically or mentally handicapped.
- nutritional counseling.
- pain management programs (Except for physician prescribed TENS units).
- palliative or cosmetic foot care including flat foot conditions, supportive devices for the foot, the treatment of subluxations of the foot, care of corns, bunions (except capsular or bone surgery), callouses, toenails, fallen arches, weak feet, chronic foot strain and symptomatic complaints of the feet.
- personal hygiene and convenience items including, but not limited to: air conditioners, humidifiers, physical fitness equipment, stair glides, elevators, lifts, "barrier free" or other home modifications, whether or not prescribed by a provider.

- support therapies, including but not limited to: marriage counseling, pastoral counseling, assertiveness training, dream therapy, music or art therapy, recreational therapy smoking cessation, and stress management.
- routine dental care.
- telephone consultations
- telephone, television, guest trays, beauty, barber and other personal service items.
- travel, whether or not prescribed by a physician.
- therapy services as a part of diabetic, developmental, pulmonary or other form of rehabilitation, except upon **prior approval** by us.
- treatment of obesity. However, we will provide benefits for the surgical treatment of morbid obesity if:
  a. your weight is at least twice the ideal weight specified for your frame, age, height and sex; and
  b. you have other medical conditions present which could be significantly and adversely affected by this degree of obesity.
- treatment leading to or in connection with transsexual surgery, artificial insemination, in vitro fertilization and embryo transplantation.
- whole blood.

ATTACHMENT C



Golden Rule

TO: File

FROM: Richard J. Ruppel
Actuarial Department

RE: Vermont Community Rating   January 21, 1992

The purpose of this memo is to estimate the rate increase that would be needed for community rates. Such rates are required to be guaranteed issue with a 12 month pre-existing provision.

Current rates being charged in Vermont are based on age, sex and family status. The average premiums and the estimated new community rates are:

	——Quarterly——		
Family Status	Current 1992 Average	Estimated Community Rated	Percent Increase
Individual	$165.64	$414.10	150%
Two Persons	324.07	810.18	150
Family	375.98	939.95	150

However, 46.3% of the Vermont individual $500 deductible policyholders are issue age 34 or younger, based on the last 80 policyholders issued $500 deductible policies in Vermont. The rates by age and percentage increases would be:

	——Quarterly——		
Age Bracket	Current Premium	Estimated Community Rate	Percent Increase
0-24	$102.77	$414.10	302.9%
25-29	124.19	414.10	233.4
30-34	139.74	414.10	196.3
35-39	160.40	414.10	158.2
40-44	184.62	414.10	124.3
45-49	205.53	414.10	101.5
50-54	238.43	414.10	73.7
55-59	292.83	414.10	41.2
60-64	354.20	414.10	16.9

This would mean that the younger policyholders would experience increases as high as 303%. If we assume that increases of approximately 200% or higher results in their deciding to drop insurance since they cannot afford it then 46.3% of Golden Rule Insurance's insured individuals would join the "uninsured" ranks.

Golden Rule Insurance Company

Home Office
Golden Rule Building
Lawrenceville, Illinois 62439-2395
Telephone (618) 943-8000

TO: File
Page 2
January 21, 1992

The projection that up to one-half of insured individuals would join the uninsured ranks is supported by the fact that 57.5% of the policyholders reported on their applications income less than $25,000. The distribution of the last 80 policyholders issued $500 deductible policies is:

$500 Deductible

Income	Count	Percent
Less than $15,000	27	33.8%
15,000-24,999	19	23.3
25,000-34,999	13	16.2
35,000-49,999	10	12.5
50,000-74,999	4	5.0
75,000-99,999	3	3.7
100,000 or More	4	5.0
	80	100.0

Assuming an average income of $17,500 for the 57.5% individuals in the two lower income brackets it is probably optimistic to think that they can afford to pay 5% more for insurance.

$17,500 x 5% = $875.00 Annually
or $223.13 Quarterly

This additional premium would still not bring the premiums for those issue ages 34 or under up to the community-rate. As stated earlier 46.3% are in the issue age 34 or under bracket.

Therefore, approximately 50% of insured individuals could possibly join the uninsured ranks. If so, this would cause the community rate to go higher since the younger individuals are dropping out.

There are currently 5,793 Vermont policyholders.

RJR:bj

50 Years of Dedication

Golden Rule®

Mr. Thomas Van Cooper
Director of Insurance Regulation
State of Vermont
Division of Insurance
Department of Banking & Insurance
State Office Building
Montpelier, VT 05602

March 5, 1992

Dear Tom:

You asked how we calculated the premium rates we would need to charge if Vermont adopts guarantee issue and community rating.

We adjusted our actual claims costs on our Vermont business by our actual past experience on guarantee issue conversion policies. Guarantee issue conversion policies cost 350% (or more) of standard rates. So as not to increase the premium inordinately, we adjusted the guarantee issue conversion experience downward.

We included claims cost trends at levels currently experienced on our health insurance block of business.

Finally, we levelized the premium, since younger people will be required to subsidize older people. The rates for the younger (under 50) ages increase dramatically. I should point out, however, that the premium rates will not drop for the older ages (ages 50 and above). The subsidies they will receive from the younger ages, who are paying as much as 300% more than current rates, are still insufficient to overcome the excess cost of guarantee issue.

You should note that our estimate of community rated premiums approximates the Blue Cross community rated premiums that I understand they are charging in Vermont.

I have discussed the Vermont proposal with our senior management. We believe that the Vermont Department of Insurance is obligated to tell the citizens of Vermont what guarantee issue and community rating will truly cost. It is clear, until we provided our information, that such information had not been disseminated and the citizens of Vermont were not informed.

Golden Rule Insurance Company

Home Office
Golden Rule Building
Lawrenceville, Illinois 62439-2395
Telephone (618) 943-8000

Mr. Thomas Van Cooper
Page 2
March 5, 1992

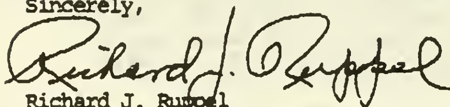
We have informally circulated our calculations among independent actuaries and they have confirmed that the increases we anticipate will be at least that much. As one actuary said: "The rates will be at least as high as you calculate and probably more."

We think it would be tragic if Vermont prohibits underwriting and requires guarantee issue and community rating. That violates every sound principle of insurance that we know.

You will no longer have insurance in Vermont, you will have socialized cross-subsidy. Healthy people will be forced to pay excessive premiums to subsidize the sick people who game the system and purchase the insurance only after they become sick. You will have more uninsureds. After all, why should a healthy person pay excessive premiums? A healthy person can simply wait until he or she gets sick.

Our calculations estimate that community rating and guarantee issue would raise rates, in some age brackets, by more than 300%. It may even be higher than that.

Sincerely,



Richard J. Ruppel
Vice President and Actuary

RJR:bj

ATTACHMENT D

CONSUMER TIPS

VERMONT DEPARTMENT OF BANKING, INSURANCE AND SECURITIES

Current Law Says:

No Vermonter Who Wants to Purchase Small Group or Individual Health Insurance May Be Turned Down

As a Vermonter, you can go to any health insurance carrier doing business in the Vermont "small group" and "individual" market, and purchase health insurance--whether you're 24 or 64, and whether you're healthy as a horse or have a history of medical problems. If you want to change insurance carriers, you do have some choice in the marketplace. You do not have to fear that no other company would take you. They must.

Consumers and health care professionals should take note that companies selling health insurance in Vermont may no longer choose who they're willing to insure on the basis of age, medical condition, sex, or virtually any other factor--a method still widely used elsewhere by insurers to screen out high risk policy holders. Companies must make all their insurance plans available to any Vermonter who wants to purchase them.

The laws which brought about these reforms in the marketplace are: Act 52, which took effect in July of 1992, and applies to companies who sell policies to small businesses; and Act 160, which took effect in July of 1993, and applies to companies who sell policies to individuals. The new laws have these two primary requirements:

(1) "Guaranteed issue" of health insurance--Insurers doing business in Vermont must sell coverage to any Vermonter who requests it. If you have a **pre-existing medical condition** you have different protections when you puchase a policy, depending on what coverage you presently have: **If you are presently without coverage, or have had your coverage for less than nine months,** a company can exclude coverage for a pre-existing medical condition, but only for a limited time (which may not exceed twelve months.) After that, the consumer is fully covered for any condition. **If you have coverage which has been**

Mailing Address: 89 Main Street, Drawer 20, Montpelier, VT 05620-3101

in effect for at least nine months, a company cannot impose a waiting period for similar coverage.

(2) Community rating--This requires insurers to charge the same premium (allowing for small deviations) to all their customers. It's a risk spreading mechanism that requires insurers to share the responsibility for coverage of all Vermonters, and thus stabilize premium costs.

As expected, some companies chose not to conform to the new laws, and left the state. The law provided a safety net program which guarantees that no insured Vermonter is left without similar coverage at a similar price because their insurance company withdrew from the market.

As a result of these changes in the law, consumers now have more choices available to them in the marketplace than before. Should you want to change your coverage in any way--for example, add or delete kinds of coverage, or find a plan that offers a higher deductible with lower premiums--shop around. A list of small group and individual (non-group) carriers is attached, as well as a listing of current premium rates.

Vermont...

Department of Banking, Insurance and Securities

REGISTERED NON GROUP CARRIERS

Carrier		Phone
Bankers Life & Casualty 22 Merchandize Mart Plaza Chicago, IL 60654-6000		(800)621-3724
Blue Cross/Blue Shield P.O. Box 186 Montpelier, VT 05601		(800)247-2583
Community Health Plan (CHP) 1201 Troy-Schnectady Road Latham, NY 12110		(800)323-3877
Harvard Community Health Plan 60 Walnut Street Wellesley, MA 02181		(800)338-4247
Matthew Thornton Health Plan P.O. Box 2028 Nashua, NH 03061-2028		(800)544-8333
Mohawk Valley Physicians Health Plan (MVP) 111 Liberty Street Schnectady, NY 12305		(800)777-4793
Mutual of Omaha Mutual of Omaha Plaza Omaha, NE 68175	Cust Service - Claims -	(800)775-6000 (800)775-1000
Time Insurance Co. P.O. Box 3050 Milwaukee, WI 53201		(800)800-1212

2/94

NON-GROUP MONTHLY COMMUNITY RATES

COMPANY	PLAN	SINGLE	2 PERSON	FAMILY
BANKERS LIFE & CASUALTY				
	$500 DED;80/20 TO $10,000	$213.39	$416.36	$524.43
PRESCRIPTION DRUGS	$1000 DED;80/20 TO $10,000	$174.07	$339.64	$439.21
$1000 MAX PER YEAR	$1000 DED HOSP-SURG	$114.54	$220.58	$284.33
COST INCL IN POLICY	$2500 DED;80/20 TO $10000	$129.69	$253.05	$361.12
	$5000 DED; 100%	$114.15	$222.73	$330.80
	$10000 DED; 100%	$74.92	$146.17	$254.25
BLUE CROSS/BLUE SHIELD				
	VFP $250	$203.00	$406.00	$548.00
PRESCRIPTION DRUGS	VFP $500	$168.00	$336.00	$454.00
$100 DED;$5/$10 COPAY	VFP $1000	$129.00	$258.00	$348.00
$2500 MAX PER YEAR	VFP $2000	$121.00	$242.00	$327.00
	VFP $5000	$96.00	$192.00	$248.00
COMMUNITY HEALTH PLAN				
	$15 CO-PAY W/50% DRUG	$183.02	$384.35	$479.74
HARVARD COMMUNITY HEALTH PLAN				
	$10 CO-PAY (NO DRUGS)	$147.40	$294.78	$397.98
MATTHEW THORNTON HEALTH PLAN				
	$10 CO-PAY (W/DRUGS)	$205.60	$411.18	$555.11
MOHAWK VALLEY HEALTH PLAN				
	$15 CO-PAY W/50% DRUG	$196.06	$392.12	$531.52
MUTUAL OF OMAHA				
	$2500 DED; 100%	$88.50	$177.00	$210.17
PRESCRIPTION DRUGS	$2500 DED HOSP-SURG	$70.71	$141.42	$167.92
$5000 PER YEAR	$3500 DED;100%	$65.11	$130.23	$175.32
COST INCL IN POLICY	$5000 DED;100%	$59.93	$119.86	$158.13
	$10000 DED;100%	$43.81	$87.63	$118.21
TIME INSURANCE				
	$500 DED; 80/20 TO $5000	$113.00	$226.00	$261.00
	TO $10,000	$96.05	$214.70	$247.95
PRESCRIPTION DRUGS	$1000 DED;80/20 TO $5000	$92.00	$184.00	$209.00
$100 DED, $8.00 COPAY	TO $10,000	$87.40	$174.80	$198.55
AGE COST	$2500 DED;80/20 TO $5000	$66.00	$132.00	$147.00
0-29 $7.00	TO $10,000	$62.70	$125.40	$139.65
30-39 $9.00	$5000 DED;80/20 TO $5000	$57.00	$114.00	$127.00
40-49 $16.00	TO $10,000	$54.15	$108.30	$120.65
50+ $22.00	$10000 DED; 100%	$33.00	$66.00	$86.00
1 CHILD $3.00	$500 DED; 50/50 TO $2500	$96.05	$192.10	$221.85
2+ CHILD $8.00	TO $5000	$72.04	$161.03	$185.96
	$1000 DED;50/50 TO $2500	$78.20	$156.40	$177.65
	TO $5000	$65.55	$131.10	$148.91
	$2500 DED;50/50 TO $2500	$56.10	$112.20	$124.95
	TO $5000	$47.03	$94.05	$104.74
	$5000 DED;50/50 TO $2500	$48.45	$96.90	$107.95
	TO $5000	$40.61	$81.23	$90.49

Vermont...

Department of Banking, Insurance and Securities

REGISTERED SMALL GROUP CARRIERS

Carrier		
American National Insurance Company One Moody Plaza Galveston, TX 77550-7999	**CLAIMS:** **CONTACT:**	1-800-899-6803 Dana Turner Lon Whitmore 603-929-0100
Blue Cross and Blue Shield 1 East Road Berlin, VT 05602	**CLAIMS:** **CONTACT:**	1-800-247-BLUE 802-223-6131
Community Health Plan (CHP) 1201 Troy Schenectady Rd. Latham, NY 12110	**CLAIMS:** **CONTACT:**	1-800-323-3877 Allen Nassif 802-447-2343
CIGNA Hartford, CT 06152	**CLAIMS:** **CONTACT:**	1-800-962-3368 Bob Crews 802-658-1970
CUNA Mutual 5910 Mineral Point Rd. Madison, WI 53701-0391	**CLAIMS:** **CONTACT:**	1-800-937-2644 Patti Haselwander 1-800-356-2644 Ext. 8783
FORTIS Benefits P.O. Box 64271 St. Paul, MN 55164-0271	**CLAIMS:** **CONTACT:**	1-800-800-2000 Pat Griffin 1-800-345-5705
Guardian Life 201 Park Ave. So. New York, NY 10003	**CLAIMS:** **BILLING:** **CONTACT:**	1-800-341-1023 1-800-772-2455 Robert Schill 802-862-6600
Harvard Community Health Plan 10 Brookline Place West Brookline, MA 02146	**MEMBER SERVICES**	1-800-338-4247

89 Main St., Drawer 20, Montpelier, VT 05620-3101
Banking, Insurance Divisions: (802) 828-3301; Securities Division: (802) 828-3420

Home Financial Services 1 Centennial Ave Piscataway, NJ 08854	**CLAIMS:** 1-800-221-3231 **CONTACT:** Garner Graves 617-237-2750
John Alden Life 7300 Corporate Center Dr. Miami, FL 33152-8060	**CLAIMS:** 1-800-327-7771 **CONTACT:** Steve Shandley 508-366-5588
Matthew Thornton Health Plan 410 Amherst Street Nashua, NH 03063	**CLAIMS** 1-800-544-8333 **MARKETING** 1-800-874-7122
Mohawk Valley Physicians Health Plan(MVP) 111 Liberty Street Schenectady, NY 12305	**CUSTOMER SERVICE** 1-800-777-4793
Pioneer Life Insurance of Illinois 304 North Main Street Rockford, Ill 61105-0120	**CLAIMS:** 1-800-950-0084 **CONTACT:** Henrietta Hopkins 1-800-950-0084
TIME Insurance Co. 501 West Michigan Milwaukee, WI 53203	**CLAIMS:** 1-800-743-TIME **CONTACT:** John Lovejoy 1-603-335-5813
TMG Life Insurance Co. 401 No. Executive Drive Brookfield, WI 53008-0980	**CLAIMS:** 1-800-558-9296 **CONTACT:** Jim Tobin 1-800-368-6785
Travelers Insurance Co. One Tower Square Hartford, CT 06183-1050	**CLAIMS:** PLAN - MI: 1-800-842-8000 PLAN - CGT: 1-800-832-8333 **CONTACT:** PLAN - MI: Arnold Gahagan 1-603-626-3166 PLAN - CGT: Michael Curry 1-800-451-8000 EXT 5022

BENEFIT PLANS – SMALL GROUP CARRIERS

	PLAN	SINGLE	2 PERSON	FAMILY
AMERICAN NATIONAL				
	$250 DED;80/20 TO $5000	$178.32	$353.47	$532.99
	$500 DED; 80/20 TO $7500	$162.54	$322.21	$485 86
	$1000 DED; 80/20 TO $10,000	$140.39	$278.31	$419 65
	$500 DED; 50/50 TO $5000	$124.92	$247 62	$373.38
BLUE CROSS/BLUE SHIELD				
FREEDOM PLAN	$100 DED;80/20 TO $500	$196.74	$393.62	$530.62
($200, $300, $500	$200 DED;80/20 TO $600	$185.71	$371.57	$500.87
OFFICE VISITS BENEFITS)	$500 DED; 80/20 TO $1500	$158.16	$316.41	$426.50
	$1000 DED; 80/20 TO $3000	$136.09	$272.28	$367.03
COMPREHENSIVE	$50 DED;80/20 TO $2000	$225.18	$450.37	$608.02
	$100 DED; 80/20 TO $3000	$208.97	$417.91	$564.23
	$300 DED; 80/20 TO $3000	$179.12	$358.24	$483.58
	$500 DED; 80/20 TO $5000	$155.47	$310.91	$419.75
	$1000 DED; 80/20 TO $	$140.01	$279.98	$378.04
MAJOR MEDICAL	PLAN J; NO DED; 80/20 TO $2000	$213.19	$427.58	$561.55
	PLAN J-W; NO DED; 80/20 TO $2000	$219.61	$440.38	$578.78
	PLAN J-Y; NO DED; 80/20 TO $2000	$229.79	$460.75	$606.30
COMMUNITY HEALTH PLAN				
	PLAN 900 ($2 CO-PAY/ 100% FERT)	$138.23	$304.59	$368.27
	PLAN 902 ($7 CO-PAY/50 % FERT)	$138.13	$304.36	$367.98
	PLAN 906 ($7 COPAY/ADD'L COPAY MENTAL)	$134.63	$296.65	$358.19
	PLAN 907 ($7 CO-PAY)	$135.44	$298.43	$360.47
	PLAN 910 ($10 CO-PAY/$500 DED HOSP/ ADD'L COPAY FOR MENTAL VISITS)	$116.38	$256.44	$296.75
	PLAN 914 (SAME AS 910 EXCEPT 50% FERT)	$116.27	$256.21	$296.45
	PLAN 926 (INCLUDES DRUGS)	$183.02	$384.35	$479.74
	PLAN 950 ($5 COPAY/ $240 DED HOSP/ ADD'L COPAY FOR MENTAL VISITS)	$122.73	$270.45	$319.79
	PLAN 951 ($5 COPAY/ 50% FERT)	$135.96	$299.57	$356.46
	PLAN 952 ($10 COPAY/ $240 DED HOSP/50% FERT/ ADD'L COPAY FOR MENTAL VISITS)	$118.14	$260.33	$301.69
	PLAN 953 ($10 COPAY/50% FERT/ $100 DED OP SURG/ADD'L FOR MENTAL)	$120.02	$264.46	$306.90
	PLAN 954 ($5 COPAY/50% FERT/$240 HOSP DED/ $100 DED OP SURG/ADD'L FOR MENTAL)	$122.63	$270.21	$319.49
	PLAN 980 ($10 COPAY/50% FERT/ER RIDER $25 COPAY	$120.18	$264.81	$302 52
	PRESCRIPTION DRUG RIDERS			
	100% DRUG	$15.42	N/A	$41.53
	80% DRUG	$11.83	$26.07	$34.61
	50% DRUG	$6.92	$15.25	$20.25
	$5 DRUG	$14.77	$32.54	$43.20
	$5/$10 DRUG	$11.47	$25.28	$33.57

BENEFIT PLANS – SMALL GROUP CARRIERS

CIGNA				
	$100 ded; 80/20 to $500	$166.45	$331.97	$528.14
	$150 ded; 80/20 to $700	$158.93	$316.96	$504.27
	$200 ded; 80/20 to $1000	$148.48	$296.09	$471.06
	$250 ded; 80/20 to $1500	$141.13	$281.47	$447.80
	$300 ded; 80/20 to $1750	$134.88	$268.60	$427.33
	$350 ded;80/20 to $1800	$131.09	$261.45	$415.95
	$400 ded; 80/20 to $1850	$128.05	$255.38	$406.30
	$450 ded; 80/20 to $1900	$125.28	$249.86	$397.52
	$500 ded; 80/20 to $1950	$122.69	$244.69	$389.29
	$750 ded; 80/20 to $2500	$114.46	$228.28	$363.18
	$1000 ded; 80/20 to $2750	$106.65	$212.70	$338.40
PPO PLANS				
OPTION 6	$100 DED; 80/20 TO $500 IN-NETWORK $250 DED; 70/30 TO $1000 OUT-OF-NETWORK	$140.03	$279.28	$444.31
OPTION 7	$150 DED; 80/20 TO $800 IN-NETWORK $300 DED; 70/30 TO $1500 OUT-OF-NETWORK	$134.39	$268.02	$426.41
OPTION 15	$200 DED; 80/20 TO $800 IN-NETWORK $300 DED; 70/30 TO $1600 OUT-OF-NETWORK	$133.11	$265.47	$422.35
OPTION 16	$250 DED; 80/20 TO $1000 IN-NETWORK $500 DED; 70/30 TO $2000 OUT-OF-NETWORK	$128.30	$255.88	$407.10

CUNA MUTUAL				
	100 DED; 90/10 TO $4000	$201.60	$393.53	$572.96
	100 DED; 80/20	$191.52	$373.85	$544.31
	$250 DED; 80/20	$145.96	$284.91	$411.23
	$500 DED; 80/20	$133.06	$259.73	$368.82

FORTIS BENEFITS				
	$100 DED; 80/20 TO $600	$173.37	$346.74	$470.48
	TO $1100	$168.04	$336.07	$456.66
	$150 DED; 80/20 TO $650	$166.76	$333.51	$449.64
	TO $1150	$161.60	$323.19	$436.33
	$200 DED; 80/20 TO $700	$158.82	$317.63	$426.78
	TO $1200	$153.88	$307.76	$414.07
	$250 DED; 80/20 TO $750	$154.22	$308.42	$414.27
	TO $1250	$149.40	$298.80	$401.85
	$500 DED; 80/20 TO $1000	$140.52	$281.02	$367.81
	TO $1500	$136.16	$272.31	$356.80
	$1000 DED; 80/20 TO $1500	$125.94	$251.88	$329.00
	TO $2000	$122.06	$244.11	$319.15

BENEFIT PLANS – SMALL GROUP CARRIERS

GUARDIAN			
$100 ded; 80/20 to $2000	$151.77	$330.77	$487.40
$200 ded; " " "	$144.57	$315.25	$464.60
$300 ded; " " "	$138.03	$301.16	$443.89
$500 ded; " " "	$133.13	$282.60	$413.39
$750 ded; " " "	$124.39	$264.32	$386.76
$1000 ded; " " "	$116.52	$260.70	$386.86
HARVARD COMMUNITY HEALTH PLAN			
CLASSIC-A $5 CO-PAY	$177.84	$355.68	$515 74
CLASSIC-G $10 CO-PAY	$164.69	$329.38	$477.60
HOME LIFE FINANCIAL			
$200 DED; 80/20 TO $5000	$113.70	$244.46	$346.79
$300 DED; " "	$106.45	$228.86	$324.66
$500 DED; " "	$97.98	$210.65	$298.93
$1000 DED; " "	$82.25	$176.84	$250.87
$200 DED; 50/50 TO $2000	$91.36	$196.41	$278.63
$300 DED; " "	$87.51	$188.14	$266.90
$500 DED; " "	$81.74	$175.74	$249.30
$1000 DED; " "	$72.12	$155.06	$219.97
$200 DED; 50/50 TO $5000	$80.44	$172.94	$245.34
$300 DED; " "	$77.05	$165.66	$235.01
$500 DED; " "	$71.97	$154.74	$219.51
$1000 DED; " "	$63.50	$136.53	$193.69
JOHN ALDEN LIFE			
$100 DED; 80/20 TO $2000	$188.57	$402.11	$505.91
TO $2500	$185.17	$394.87	$496.80
TO $5000	$172.81	$368.51	$463.64
TO $5000	$126.21	$269.14	$338.62
$1000 DED;80/20 TO $2000	$112.10	$239.05	$300.75
TO $2500	$109.84	$234.23	$294.70
TO $5000	$102.58	$218.75	$275.21
$2500 DED;80/20 TO $2000	$85.97	$183.32	$230.64
TO $2500	$84.38	$179.93	$226.38
TO $5000	$80.71	$172.11	$216.53
MATTHEW THORNTON HEALTH PLAN			
$5 CO-PAY; O IN-HOSP CO-PAY;$5 DRUG CO-PAY	$197.76	$395.53	$533.96
$5 CO-PAY; $250 IN-HOSP CO-PAY; $5 DRUG CO-PAY	$195.82	$391.64	$528.71
$10 CO-PAY;$250 IN-HOSP CO-PAY;$10 DRUG CO-PAY	$187.60	$375.19	$506.51
$10 CO-PAY;$500 IN-HOSP CO-PAY; NO DRUGS	$172.28	$344.56	$465.15

MOHAWK VALLEY PHYSICIANS HEALTH PLAN			
$5 CO-PAY;$240 IN-HOSP CO-PAY;$10/5 DRUG CO-PAY	$174.39	$305.80	$438.60
$10 CO-PAY;$240 IN-HOSP CO-PAY;$10/5 DRUG CO-PAY	$123.55	$246.12	$354.30
$15 CO-PAY;$240 IN-HOSP CO-PAY;$10/5 DRUG CO-PAY	$115.36	$229.74	$331.17
$15 CO-PAY;NO IN-HOSP CO-PAY;$10/5 DRUG CO-PAY	$117.94	$234.90	$338.45
PIONEER			
$400 DED; 80/20 TO $5000	$88.98	$151.27	$240.25
TO $12,500	$75.64	$151.28	$204.23
50/50 TO $5000	$66.74	$133.48	$180.20
$800 DED; 80/20 TO $5000	$74.92	$127.37	$202.29
TO $12,500	$63.69	$127.38	$171.96
50/50 TO $5000	$56.20	$112.39	$151.73
$1200 DED; 80/20 TO $5000	$71.81	$122.07	$193.88
TO $12,500	$61.04	$122.08	$164.81
50/50 TO $5000	$53.86	$107.72	$145.42
TIME INSURANCE			
$250 DED; 50/50 TO $5000	$90.26	$192.06	$260.19
TO $10,000	$80.81	$171.84	$232.82
80/20 TO $5000	$125.70	$267.87	$362.85
TO $10,000	$120.97	$257.76	$349.16
$500 DED; 50/50 TO $5000	$79.51	$169.06	$229.05
TO $10,000	$71.29	$151.47	$205.24
80/20 TO $5000	$110.34	$235.02	$318.36
TO $10,000	$106.23	$226.22	$306.45
$1000 DED; 50/50 TO $5000	$68.77	$146.06	$197.92
TO $10,000	$61.77	$131.10	$177.66
80/20 TO $5000	$94.99	$202.17	$273.88
TO $10,000	$91.42	$194.69	$263.75

TMG LIFE

Plan				
$100 DED; 80/20 TO $2500		$170.20	$389.15	$512.59
	TO $5000	$163.39	$373.58	$492.09
$150 DED; 80/20 TO $2500		$161.69	$369.69	$486.96
	TO $5000	$155.22	$354.90	$467.48
$200 DED; 80/20 TO $2500		$154.88	$354.13	$466.46
	TO $5000	$148.69	$339.96	$447.80
$250 DED; 80/20 TO $2500		$149.78	$342.45	$451.08
	TO $5000	$143.78	$328.75	$433.04
$300 DED; 80/20 TO $2500		$144.67	$330.78	$435.70
	TO $5000	$138.88	$317.55	$418.27
$500 DED; 80/20 TO $2500		$129.35	$295.75	$389.57
	TO $5000	$124.18	$283.92	$373.99
$750 DED; 80/20 TO $2500		$119.14	$272.41	$358.81
	TO $5000	$114.37	$261.51	$344.46
$1000 DED; 80/20 TO $2500		$110.63	$252.95	$333.18
	TO $5000	$106.20	$242.83	$319.86
$2000 DED; 80/20 TO $2500		$85.10	$194.58	$256.30
	TO $5000	$81.70	$186.79	$246.04
	********************			
$100 DED; 70/30 TO $2500		$159.99	$365.80	$481.83
	TO $5000	$153.59	$351.17	$462.56
$150 DED; 70/30 TO $2500		$151.99	$347.51	$457.74
	TO $5000	$145.91	$333.61	$439.43
$200 DED; 70/30 TO $2500		$145.59	$332.88	$438.47
	TO $5000	$139.77	$319.56	$420.93
$250 DED; 70/30 TO $2500		$140.79	$321.90	$424.01
	TO $5000	$135.16	$309.03	$407.05
$300 DED; 70/30 TO $2500		$135.99	$310.93	$409.56
	TO $5000	$130.55	$298.49	$393.18
$500 DED; 70/30 TO $2500		$121.59	$278.01	$366.19
	TO $5000	$116.73	$266.89	$351.55
$750 DED; 70/30 TO $2500		$111.99	$256.06	$337.28
	TO $5000	$107.51	$245.82	$323.79
$1000 DED; 70/30 TO $2500		$103.99	$237.77	$313.19
	TO $5000	$99.83	$228.26	$300.66
$2000 DED; 70/30 TO $2500		$79.99	$182.90	$240.92
	TO $5000	$76.79	$175.58	$231.28

TRAVELERS INSURANCE COMPANY			
90–M $100 DED; 80/20 TO $1000	$210 39	$443.93	$629.07
MI–J $200 DED; 80/20 TO $1000	$196.68	$414 98	$588.06
86–L $200 DED; 80/20 TO $2000	$193.25	$407.75	$577 80
90–N $200 DED; 80/20 TO $1500	$194.28	$409.92	$580.88
90–O $300 DED; 80/20 TO $1500	$180.56	$380.98	$539.86
MI–K $300 DED; 80/20 TO $1500	$182.96	$386.04	$547.04
MI–L $500 DED; 80/20 TO $2000	$158.95	$335.39	$475.26
90–P $500 DED; 80/20 TO $3000	$161.52	$340.82	$482.95
MI–A $200 DED; 50/50 TO $2000	$155.52	$328.15	$465.01
MI–B $500 DED; 50/50 TO $3000	$125.69	$265.20	$375.80
MI–H $1000 DED; 50/50 TO $3000	$118.83	$250.73	$355.29
MI–C $250 DED; 70/30 TO $1500	$171.47	$361.80	$512.69
MI–E $500 DED; 70/30 TO $1500	$153.12	$323.09	$457.83
MI–F $1000 DED; 70/30 TO $1500	$129.80	$273.88	$388.11
CGT PLANS			
$250 DED; 50/50 TO $1000	$166.33	$350.95	$497.31
TO $2500	$144.55	$305.00	$432.20
$500 DED; 50/50 TO $1000	$151.24	$319.11	$452.19
TO $2500	$131.52	$277.50	$393.23
$1000 DED; 50/50 TO $1000	$133.40	$281.48	$398.87
TO $2500	$116.09	$244.94	$347.09
$250 DED; 80/20 TO $1000	$180.73	$381.34	$540.38
$500 DED; 80/20 TO $1000	$164.44	$346.97	$491.67
$1000 DED; 80/20 TO $1000	$145.06	$306.08	$433.74

ATTACHMENT E

15. Has any person named in #1, within the last 10 years, had any indication, diagnosis, or treatment — Yes No
a. any disorder of the heart or circulatory system, including high blood pressure, anemia, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis, or stroke? ☐ ☐
b. cancer, tumor, cyst, polyp or growth of any kind, or skin disorder or disease? ☐ ☐
c. any blood abnormalities, immune system deficiencies, or sexually transmitted diseases? ☐ ☐
d. any disorders of the nervous system (including epilepsy, convulsions, headaches, paralysis, or mental illness), nervousness, emotional or behavioral disorders; or consulted with a psychologist or psychiatrist? ☐ ☐
e. any disorder of the digestive system (including ulcer, gastritis, intestinal disorders, colitis, gall stone, hemorrhoids, bloody stools, or hernia); or disorder of the pancreas, liver, spleen, or gallbladder? ☐ ☐
f. diabetes, sugar in the urine, or disorder of the thyroid, breast or other glands? ☐ ☐
g. any disorder of the muscular or skeletal systems, including arthritis, gout, rheumatism, or any jaw, knee, back, or spine disorders? ☐ ☐
h. any disorder of the lungs or respiratory system, including allergies, asthma, bronchitis, tuberculosis, or emphysema? ☐ ☐
i. any disorder of the genito-urinary system, including kidney disorder, kidney stones, cystitis, prostatitis, bladder infections, or blood in the urine? ☐ ☐
j. any disorder of the male or female reproductive organs, prostate problems, irregular menstruation, abnormal pap test, or pregnancy complications, including Cesarean Section delivery? ☐ ☐
k. any disorder of the eyes, ears, nose or throat, including impaired sight or hearing, earaches, or tonsillitis? ☐ ☐

16. **Has any person named in #1, within the past 5 years:** — Yes No
a. had any indication, diagnosis, or treatment of alcohol or drug dependency, abuse, or reaction? ☐ ☐
b. used any drug not prescribed, such as opiates, stimulants, depressants, and/or hallucinogens? ☐ ☐

17. **Is any person named in #1 currently:**
a. taking medication or receiving medical treatment of any kind? ☐ ☐
b. a user of alcoholic beverages in excess of 14 drinks per week? If yes, show who and how many drinks per week in #21 below. ☐ ☐
(one drink equals: 12 oz. of beer; 4 oz. of wine, 1 oz. of hard liquor)

18. **Is any family member (whether or not named in this application) pregnant? If yes, show expected delivery date in #21.** ☐ ☐

19. **Has any person named in #1, within the last 10 years, been hospital confined, had surgery, or discussed surgery with a doctor?** — Yes No ☐ ☐

20. **What are the names of all doctors consulted in the past 5 years by persons named on this application?** List the doctors' names and give full details in #21 below.

21. **IMPORTANT: Give complete details of any "Yes" answers to questions 11 thru 19 and respond to question 20.**

Question Number	Person (Line #)	Symptoms or Condition	Dates	Treatment, Advice Given, Results, and other details	Name and Address of Doctors and Hospitals

(If more space is needed, attach a supplement and sign it. Check this box ☐ if anything is attached.)

22. Requested Effective Date: (See Conditional Receipt)

I have personally completed this application and I represent that the answers and statements on this application are true, complete, and correctly recorded to the best of my knowledge.

I UNDERSTAND AND AGREE that, (1) the statements and answers given in this application, and in any supplements or amendments to it, will form the basis of, and be made a part of, any policy which may be issued; (2) any incorrect or incomplete information on this application may result in loss of coverage or claim denial, (3) in accordance with the conditional receipt given to me, this application and the payment of the initial premium does not give me immediate coverage; (4) the agent or broker: is only authorized to submit the application and initial premium; may not change any application, policy, or receipt; and cannot waive any right or requirement; and (5) coverage for illness does not begin until the 15th day after a person becomes insured for injury. I have received the Notice of Information Practices.

Signed ___/___/___ at __________ X __________
Date — City — State — Signature of Proposed Insured (You)

X __________ X __________
Signature of Parent/Guardian (If you are a minor) — Signature of Spouse (If to be covered)

REVIEW THE COMPLETED APPLICATION BEFORE SIGNING

GRI-AF-9 1

For Agent/Broker

Each question on this application was completed by the applicant(s). I have personally witnessed the reading, completion, and signing of this application.	Unless I have given a different response below, the response shown for question 10 on this application reflects my understanding and response to the question "Will the plan applied for replace or change any existing insurance or annuities?" ☐ Yes ☐ No
I have collected the initial premium and given the conditional receipt.	

Signature of Licensed Agent or Broker — Print Full Name — Agent/Broker #

Golden Rule will act on this application as quickly as possible. The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for any further delay.

7231-490

No application will be accepted in the Home Office or Executive Office more than 15 days after the date signed.

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

ATTACHMENT F

A study of the first 1,064 Vermont Health Insurance Safety Net subscribers found that approximately 20% had had one or more condition excluded from coverage in their previous policy. While not all of these subscribers had been covered by Golden Rule, Blue Cross and Blue Shield of Vermont records would indicate that greater than 96% of all of these subscriber had had Golden Rule coverage. The 1,024 former Golden Rule policyholders had a total of 1,245 separate exclusion added to their policies. The most common exclusions included Allergies, Back Disorders, Eye Disorders, Sinus Disorders and Hayfever, however such medical problems as Kidney Disease, Heart Disease, Ulcers, Tumors and Diabetes were also routinely excluded. The following is a sampling of former Golden Rule policyholders with exclusions.

Subscriber A applied for health insurance from Golden Rule on March 31, 1996. Subscriber had been treated by physician for neck injury and whiplash in January 1, 1985. Golden Rule excluded any loss incurred resulting from any injury to, disease or disorder of the spinal column, including vertebrae, intervertebral discs, spinal cord, nerves, surrounding ligaments and muscles, including complications therefrom or operation therefor. The exclusions was in force at the time Golden Rule terminated coverage on October 3, 1992.

Subscriber B applied for health insurance from Golden Rule on September 18, 1991. Subscriber had been treated by physician in June 1991 for bumps on skin that were determined to be fatty deposits of no concern. Golden Rule excluded any loss incurred resulting from any form of tumor or tumorous growth, including complications therefrom or operation therefor. The exclusions was in force at the time Golden Rule terminated coverage on November 1, 1992.

Subscriber B had also been treated for a back injury which occurred at place of employment in June 1989. Golden Rule excluded any loss incurred resulting from any injury to, disease or disorder of the spinal column, including vertebrae, intervertebral discs, spinal cord, nerves, surrounding ligaments and muscles, including complications therefrom or operation therefor. The exclusions was in force at the time Golden Rule terminated coverage on November 1, 1992.

Dependent of Subscriber B was treated from November 1990 to June 1991 for chiropractic maintenance. No other indication of back injury, spinal problems, etc., were indicated on Golden Rule application. Golden Rule excluded any loss incurred resulting from any injury to, disease or disorder of the spinal column, including vertebrae, intervertebral discs, spinal cord, nerves, surrounding ligaments and muscles, including complications therefrom or operation therefor. The exclusions was in force at the time Golden Rule terminated coverage on November 1, 1992.

Subscriber C applied for health insurance from Golden Rule on July 8, 1991. Subscriber had been treated by physician in August 1990 for unstable sacro-illiac joint, treatment included sclerotherapy, injections of solution to help the body form scar tissue to hold the joint in place. Golden Rule excluded any loss incurred resulting from any injury to, disease or

disorder of the spinal column, including vertebrae, intervertebral discs, spinal cord, nerves, surrounding ligaments and muscles, including complications therefrom or operation therefor. The exclusions was in force at the time Golden Rule terminated coverage on July 19, 1993.

Subscriber C also treated with aspiration of fluid in benign cysts located in breasts. Golden Rule excluded any loss incurred resulting from any disease or disorder of the breats, including complications therefrom. This included any reconstructive surgery or complications of reconstructive surgery. The exclusion was in force at the time Golden Rule terminated coverage on July 19, 1993.

Also excluded from Subscriber C's policy was any loss incurred resulting from angioma or hemangioma, including complications therefrom or operation therefor. The exclusion was in force at the time Golden Rule terminated coverage on July 19, 1993.

Subscriber D applied for health insurance from Golden Rule in December 1990. Dependent of Subscriber B was treated twice prior to June 1988 due to the appearance of blood found in the stools, no recurrence had been experienced. Golden Rule excluded any loss incurred resulting from any disease or disorder of the rectum or anus. The exclusion was in force at the time Golden Rule terminated coverage on February 15, 1992.

Subscriber E applied for health insurance from Golden Rule on December 14, 1991. Subscriber indicated on application that she had noticed varicose veins, but had experienced no problems and had not seen a doctor regarding them. Golden Rule excluded any loss incurred resulting from varicose veins, phlebitis, or thrombosis, including complications therefrom or operation therefor. The exclusion was in force at the time Golden Rule terminated coverage on December 24, 1992.

Subscriber F applied for health insurance from Golden Rule on January 15, 1992. Subscriber, a self-employed commercial painting contractor, indicated no experience with back problems. Golden Rule excluded any loss incurred resulting from any injury to, disease or disorder of the spinal column, including vertebrae, intervertebral discs, spinal cord, nerves, surrounding ligaments and muscles, including complications therefrom or operation therefor. The exclusions was in force at the time Golden Rule terminated coverage on March 1, 1993.

Additionally, Golden Rule excluded family members from their policies when deemed medically high risks. A sampling of these follows.

Subscriber 1 had been on Golden Rule policy since November 16, 1991. Subscriber's spouse had been excluded from the policy by Golden Rule. Safety Net policy became effective on November 16, 1992. As of July 1993, 92% of claims payments made on this certificate had been for previously excluded member.

Subscriber 2 had been on Golden Rule policy since October 1, 1990. Subscriber's spouse had been excluded from the policy by Golden Rule. Safety Net policy became effective on October 1, 1992. As of July 1993, 6% of the claims payments made on this certificate had been for previously excluded member. This policy also included an exclusion for loss incurred resulting from hearing diseases or disorders in regard to the continuously covered member.

ATTACHMENT G

[illegible]
[illegible] AMPUTATION Right Arm injury, disease, revision or artificial attachment
[illegible] AMPUTATION Left Arm injury, disease, revision or artificial attachment
[illegible] AMPUTATION Right leg injury, disease, revision or artificial attachment
[illegible] AMPUTATION Left leg injury, disease, revision or artificial attachment
AF ANAL FISSURE, FISTULA
AG ANEMIA
AH APPENDICITIS OR APPENDECTOMY
AI ARM (Right) injury, disease or disorder
AJ ARM (Left) injury, disease or disorder
[illegible] ARTHRITIS
[illegible] ATAXIA disease or disorder of central nervous system
[illegible] ACID PEPTIC DISEASE of the esophagus, stomach or intestines
[illegible] SUPRA-VENTRICULAR ARRHYTHMIAS atrial flutter, paroxysmal tachycardia
[illegible] ADHESIONS
[illegible] Asthma
BA BEE STINGS allergic reactions to bees or other stinging insects
BB BELL'S PALSY OR FACIAL PARALYSIS treatment or operation
BC BONE TUMOR malignancy, spread or metastasis
8D BLOOD PRESSURE additional deductible ($100) + $400
8E BLOOD PRESSURE additional deductible ($150) + $400
BF BACK DISORDERS spinal column, vertebrae, intervertebral discs, ligaments
BG BREAST DISORDERS disease, disorder, reconstruction surgery
BH BRONCHITIS, bronchitis or disease or disorder of the lungs
BJ BURSITIS- synovitis or tenosynovitis including treatment or operations
8R RAISED DEDUCTIBLE, benefits amended to add an additional $400 per year
CE CLEFT PALATE - cleft lip including complications or operation
[illegible] COLITIS including irritable bowel syndrome and any complications
CI CYSTITIS - inflammation or disorder of the urinary bladder
[illegible] EARS, Disease of the ears or mastoids
DE ENDOMETRIOSIS
DI EYES, injury to or disease or disorder of the eyes
EI EAR, LEFT DISEASE OF OR MASTOID
FE Bunions, hallux varus, hallux valgus including complications
FF FEET- disease or disorder of the feet including the calcaneous, etc.
FG FOOT (Right), injury, disease or disorder of the right foot
GA Gall Bladder-biliary ducts any disease or disorder
GD Female Genitourinary Disorders, genital tract, cervix and ovaries
GH GLAUCOMA
GL GASTROINTESTINAL DISORDERS OR DISEASE , STOMACH & INTESTINES
HC HERNIA - including complications or operation
HE HEARING LOSS, examination, treatment and/or surgery to restore
HG HIP DISORDERS - any injury to, disease of, treatment or operative repair
HN Hyperactivity-hyperkinesis and or disorder
HO HEART DISEASE, congenital
HY HYPERTENSION
I8 Infertility or artificial insemination
IG IMMUNOTHERAPY, allergy testing or immunotherapy and administration
K9 KNEE (RIGHT), injury to, disease or disorder of the right knee
KD INJURY TO, DISEASE, OR DISORDER OF THE KNEES
KE KIDNEY STONE - gravel, or colic of the urinary tract
LJ LEG, LEFT - any injury to, disease or disorder of the left leg.
LK CHOLESTEROL/LIPIDS, elevated, hypercholesterolemia, hyperlipidemia
MC MENTAL AND NERVOUS DISORDERS
MD MENTAL OR EMOTIONAL DISORDERS, anxiety, depression, examination
ME MITRAL VALVE PROLAPSE
MG MUSCLE DISORDERS, inflammatory condition of muscles, tendons, tissue
NB ANKLE, RIGHT any injury to, disease, or disorder
NE HAND, LEFT - any injury to, disease, or disorder of left hand.
NF Nasal Passages-any disease or disorder of the pharynx
NK HAND, RIGHT DISEASE OR DISORDER OF
PK Pregnancy Complications
PL Prostate, Prostatitis any disease
PQ CAESAREN DELIVERY, childbirth by caesarean delivery or complications
PS PSORIASIS
PW Planter Warts
SA SEXUALLY TRANSMITTED DISEASES
SB Shoulder, Right any loss or injury including complications.
SD Skin Disorders -disease or disorder of the skin
SH MOTORCYCLE, injury sustained while operating or riding a motorcycle
SI Scuba or Skin any injury resulting
SJ HANG GLIDING - any injury sustained
SP SPINAL COLUMN
TA Jaw Disorders - Temporomandibular joint disorders or disease, operation.
TE TESTES, disease or disorder of the testes
TC THYROID - disease, dysfunction or disorder of the thyroid gland
TG TUMOR
UA ULCERS, ulcers or any disease of the stomach or duodenum
US Urinary System-any diease or disorder or complications
VB VARICOSE VEINS, varicose veins, phlebitis, or thrombosis
XJ INCREASED DEDUCTIBLE BY $400 due to asthma and/or allergies

Mr. DINGELL. Mr. Van Cooper, you have given the committee a most helpful and thoughtful statement for which we thank you.

Mr. VAN COOPER. Thank you, Mr. Chairman.

Mr. DINGELL. I want to commend you for the vigorous way in which you are addressing your problems up there in Vermont.

Mr. VAN COOPER. Thank you.

Mr. DINGELL. The next panel member is Mr. Foley.

Mr. Foley, we thank you for being us with and we look forward to your statement.

TESTIMONY OF TOM FOLEY

Mr. FOLEY. Thank you, Mr. Chairman and Members. I am Tom Foley, I am an Actuary in the Florida Department of Insurance. I am delighted to be here today to address you. I have prepared written comments. I believe you have copies of those.

If you would look at page 12, which is a summary page, that is the page I am going to be speaking from this morning.

What I would like to do is talk about the pattern that we see for individual and small group insurance and how that evolves and indeed how that causes health care costs to increase, not decrease or moderate. I would like to begin——

Mr. DINGELL. Without objection, we will then insert your full statement in the record and recognize you for such comments as you choose to make.

Mr. FOLEY. Thank you.

First of all, it is very important that the committee understand how premiums are determined by minimum loss ratios and what that means. As Tom just said, a loss ratio means that if you collect a dollar in premium and you pay 60 cents in claims, then you have a 60 percent loss ratio, so minimal loss ratios mean that a portion of the premium has to be returned in the form of claims. We need to make the distinction between cost, claims, and price, premium.

The way minimum loss ratios work in individual health insurance is that we have the claim cost and then the loading, which is the difference between the premium and the claims cost, is a fixed percentage of the claims cost. For example, suppose claims are $100; the loading is 50 percent of claims. This means the premium is going to be the $100 for claims plus 50 percent of that $100 or the premium is going to be $150.

Suppose the claims on the other hand are $300, then 50 percent of $300 is $150, so then the premium is going to be $450. The point I am trying to make is that since the loading is a fixed percentage of claims, companies can increase their profit by having claims increase, not decrease, which means that in this cost-plus system, to reiterate, they can increase profits by increasing claims.

Let's see how they do that, then. We look at the pattern that develops. As Tom just indicated, companies offer coverage only to healthy people. They are not going to offer a policy unless you are healthy or if they do offer one, they are going to put exclusions on the policy.

The initial premiums that are determined by the company are to cover just the low initial claim level, so basically the initial premiums are inadequate in an ongoing sense because companies are interested in securing market share. They want to have the lowest

going-in premium that they can have so they will be attractive to the market. So they offer this product for 1 to 3 years, and then they discontinue sales under that product.

The reason that they do that, and it generates what is called a "closed block" of business, the reason that they close the block of business is then they won't have any new insureds coming in that will hold down the claim cost level because after several years, people develop sicknesses, they develop injuries, they have claims. So the claim costs escalate.

As the claims cost escalate, as I just indicated to you, that automatically drives the premiums up because the premiums go ahead of claims in this automatic fashion under minimum loss ratios. So the premiums increase dramatically.

Suppose you are in one of these policies and you bought it 2 years ago and you are still healthy. If you are still healthy, then you can walk down the street, buy a new policy from another company, start over with a new low premium and start the cycle all over again. If you are not—if you are no longer healthy, if you can no longer qualify, then you are stuck in that "closed block" of business, which means that as more and more healthy people leave and more and more unhealthy people stay, the premium ratchets up that much more. And again it is important for the committee to understand that this loading is fixed and so it is in the company's vested interest to have claims increase because that increases the premium, which increases their profit. Again, so the unhealthy who can't get coverage elsewhere must stay with that closed block of business, and we end up with what is called a "death spiral," with premiums escalating 20 and 30 and 40 percent in renewal years. And I have a chart in a minute that will show that. In fact, why don't we go to that.

Appendix A, in my written comments is a 4-year rate increase comparison which shows the five leading individual health insurance writers in Florida, and what their rate increase experience has been in the last 4 years. You notice that Blue Cross and Time Insurance Company, their average rate increase for this 4-year period of time has been about 20 percent.

Union Bankers and Mutual of Omaha, their average rate increase has been close to 30 percent or at 30 percent. Golden Rule, their average rate increase over four blocks of business for the last 4 years has been 45 percent, which means——

Mr. DINGELL. Is that per year, Mr. Foley?

Mr. FOLEY. That is exactly right, that is 45 percent per annum.

Mr. DINGELL. It has gone up 45 percent per year?

Mr. FOLEY. That is right. What that means, Mr. Chairman, is that if you look at the second line in appendix A, if you take a $1,000 premium that somebody paid initially 4 years ago under Blue Cross, with a 21 percent compound increase, that $1,000 premium is now $2,134.

Under Golden Rule with a 45 percent compound increase, that $1,000 premium is now $4,490. We would contend that that kind of system does not work for policyholders.

People start out with unrealistically low premiums and then because of the nature that I just described, you take only healthy lives, in a couple years the healthy lives leave because they want

to go back and get a new policy and start over with a new low premium, so that leaves just the unhealthy lives. So we start ratcheting upwards, and that is what we call a "death spiral." And as you can see, of the top five writers in Florida, some companies make more of an effort than others to make the initial premium adequate so that renewal rate increases won't be substantial.

If you will look at Appendix B, which is an attempt to show you how community rating compares with the kind of rating that we just talked about. I mislabeled the heading of Appendix B. That should be "equivalent revenue patterns" and not "premium patterns."

Mr. Chairman, what I tried to do here under community rating, let's suppose we start with a premium of $100, and this is an index. I am not saying that anybody's premium would be $100, but suppose it were, and suppose that underlying health care costs go up 5 percent a year. Then we would get the pattern under column A for people with a community-rated system, because with community rating basically what we are doing is we are taking the total cost, dividing by the number of people, and everybody is going to pay about the same.

Now, we can adjust that for age, we can adjust it for gender, but instead of having very healthy people pay a low premium and unhealthy people pay an exorbitant premium, what community rating does is try to have everybody, the healthy people pay a little bit more so the unhealthy people don't have to pay as much. So we get that premium pattern that we see in column A.

On the other hand, if you have a 30 percent rate increase, renewal rate increase, now keep in mind that was in the middle of the chart we just looked at, if you look in column D, instead of starting with a $100 premium, we would start with a $78 premium, again that is the lower premium because we are only dealing with healthy people, but look at the renewal pattern. By the time we get to year 5, instead of paying $122 under the community-rated scheme, now we are paying $223, and it just gets worse from there.

It is our contention that the kind of patterns represented by C and D, do not work for policyholders. Let me just take a minute or 2 and talk about some of the things that we have done in Florida to stop this kind of abuse.

And as Tom just indicated, as they have done in Vermont, we have adopted the NAIC model for small group reform, we have enhanced that model even more, and in 1994. And what we have is a system wherein the small group market, which is defined to be 1 to 50 employees, so it includes 1 and 2 person groups, all carriers writing this market have to offer products of guarantee issue, they can't do medical underwriting, they have to use modified community rating, which means that rates can vary in our case, by age and gender and geographic area and family composition and tobacco usage.

They have to offer the same standardized policies and they have to use the same premium format. What that allows us to do is put together premium comparisons—and, Mr. Chairman, there are examples of these in the documents which we can go through later, if you would like—but what that allows us to do in summary is to bring the competitive marketplace to bear for small groups, and we are trying to get also for individual coverage in Florida to bring the competitive marketplace to bear which will hold down claim costs rather than have them ratchet up like we have had in the system.

Thank you.

[The prepared statement of Mr. Foley follows:]

STATEMENT OF TOM FOLEY

HISTORY

The level and rate of increase of health care costs in America are both at a non-sustainable level. Various activities of health insurance companies are major contributing factors to these problems. Health insurance reforms implemented and proposed in Florida are presented for consideration as possible national insurance reforms.

As a measure of the level of health care spending, the projected health care expenditure in Florida for 1994 is $50 billion. This is about $3,600 for every person in the state. $300 per month per person or $1,200 per month for a family of 4. Since a significant portion of the population pays little, if anything, towards health care costs, many are paying much more than the $300 average. And many of these costs are hidden in the form of employer paid premiums, increased consumer prices, low copays and cost shifting.

The rate of increase in health care expenditures has been 10-14% for the last several years as measured by federal studies and by renewal year rate increases on large group plans. This rate of increase is 2-3 times as great as the general inflation rate as measured by the consumer price index.

The following activities, many involving the health insurance industry, have been identified as contributing to the level and rate of increase in costs.

1. Employer paid health premiums are fully deductible for federal income tax calculations. Of even greater importance for this discussion, this premium is not included in the employee's income for federal tax calculations.

2. Non-employer paid health insurance premiums must be funded from "after-tax" income.

3. Because of this difference in tax-treatment, employer paid health plans have been designed to provide "full coverage". Higher benefits can be provided at less immediate cost in employer paid plans because of this tax-differential.

4. Therefore, for the last 50 years, the clear message sent to hospitals and physicians has been "you do it and we (the insurance policy) will pay for it". This policy design provides hospitals and physicians with a virtual blank check in exchange for providing care.

5. Note that the care paid for by health insurance policies is limited to performing corrective procedures for accidents and illnesses, but not for preventative care. It is not unexpected that the emphasis in our health care system is on providing treatment, not on preventing the need for treatment.

6. The resulting increase in health care expenditures received a major boost in the early 1970's when general wage/price controls were implemented and released. In 1974, when controls were released, there was a significant spike in health provider costs to recoup the "loss" of the previous three years.

7. In response to this significant increase in costs, many employers requested that their group health insurance premiums be lowered because they had a healthy group of employees. Generally, before this time, insurers used little, if any, medical underwriting and determined premiums using what today is referred to as modified community rating.

8. On the surface, this is appealing. After all, if an individual or group is healthy, why shouldn't their premium directly reflect it. However, the natural consequence

of providing lower rates for healthy people is that unhealthy people must pay much more or go without coverage.

9. So, what has developed in the last 20 years is a health insurance system that is designed to cover people when they are well and makes every effort to eliminate their coverage when they become unhealthy. Clearly, some changes are needed.

10. Another key component is the method that has been used for the last 20 years by the insurance industry to develop initial and renewal premiums. Premiums are determined to be not excessive if they meet a minimum loss ratio over the life of the policy. This means that the claims paid under the policy are at least a minimum percentage of the premium paid.

11. This minimum loss ratio method yields a cost/plus system for determining premiums. If the minimum loss ratio is 70% and claims are $1050, then the maximum premium is $1500 (=1000/.7). The portion of the premium for non-claim expenses is $450 (=1500-1050). However, if the claims are twice as high, ($2100), then the premium is twice as high, $3000 and the non-expense portion of the premium is twice as high, $900.

12. So, this cost/plus system tends to encourage insurers to INCREASE claims, as this increases the dollar amount for non-claim expenses, and therefore, the amount available for profit. Both steps 11 and 12 are made possible because health insurance policies have not been standardized and therefore, have not been comparable. If they were, then competitive market pressures could be used to reduce premiums.

13. Another major consequence is that the person paying the premium is on the risk for increases in claims, not the insurer, not the provider. So, the current "pass-through" system does not put any pressure on insurers or providers to provide high quality care AT LOW COST. The motivation indeed is in the opposite direction.

14. Some will argue that the managed care or gate-keeper movement of the last 10-15 years does make an effort to reduce costs. This seems to be a "band-aid" that attempts to have one group, the insurers, hire providers to look over the shoulder of the providers giving care. Most would agree that this technique is not the optimum solution.

15. Another segment of the health insurance market that potentially increases consumer costs is supplemental insurance. These products include policies that cover hospital stays, surgeries, drugs, dread diseases (cancer) and mental health. These policies were originally developed to provide coverage to those who could not afford comprehensive coverage, but now most are sold in addition to comprehensive coverage.

16. Supplemental policies potentially increase overall consumer costs in at least two ways. First, by providing benefits that duplicate comprehensive coverage, they serve as a incentive to overutilize health care services by allowing a insured to get paid twice for their care.

17. In addition, by selling coverage in small packages, the consumer is paying duplicative expense charges to insurers. Certain non-benefit expense costs are fixed for each policy sold and maintained. If an insured has 5 policies rather than 1, then they are paying these fixed costs 5 times rather than once.

In summary, the individual and small group health insurance is characterized by:

1. High medical care costs.

2. High rate of increase in medical care costs.

3. Incentives in health insurance policies for medical providers to increase health care costs, not reduce them.

4. Health insurers seeking only healthy people.

5. Incentives in health insurance policies for insurers to increase health care costs, not reduce them.

6. Increased separation of benefits activity (supplemental policies) by health insurers which increases consumer's non-claim costs and often allows policyholders to "make money" by being sick or injured.

The sections that follow will outline the changes made and proposed in Florida to alter the above.

FLORIDA INSURANCE REFORMS - SMALL GROUP

Introduction

The Florida legislature passed small group insurance reforms in 1992 and 1993. The 1992 bill adopted the National Association of Insurance Commissioners (NAIC) model bill for small group insurance reform. The 1993 bill enhanced these reforms. The major components of the 1993 bill are presented below.

Legislation

1. The definition of small group was changed from 3-25 (1992 bill) to 1-50. A study showed that over 90% of the small groups in Florida meet this definition. The effective date for the inclusion of 1 and 2 life groups was April 15, 1994 with 3-50 effective January 1, 1994. The eligible sole provider, independent contractor or self-employed person is defined as one who derived taxable income from a trade or profession as evidence by an IRS 1040 form, Schedule C or F, which showed taxable income in at least one of the two previous years.

2. All small groups must be offered the Standard and Basic plans. These plans were developed by a committee appointed by the Commissioner of Insurance and consisted of representatives of small employers, consumers, insurance companies, HMOs and two state agencies. The committee held public hearings throughout the state. The benefits under the Standard plan are about 90-95% of the benefits offered by comprehensive plans provided by national major employers. The basic plan has lesser benefits and higher copays to provide a smaller premium. Both plans are offered on an indemnity and HMO basis. An outline of the benefits is found in Appendix G.

3. All health plans offered by small group carriers to small groups must be on a guarantee issue basis. This applies to the Standard and Basic plans as well as any "street" plans offered by the carrier. A carrier can ask medical questions at time of application, but only to determine if the group or individual is to be placed in the reinsurance pool.

4. Portability is a key factor in the legislation. If an employee had previous coverage, either group or individual, and applied for coverage with his or her new employer

within 30 days, then they receive credit for any pre-existing condition provision satisfied under the prior coverage. The pre-existing condition provision in the legislation is 6/12 for all employees in groups of 3-50. That is, any condition manifesting itself within 6 months before the effective date of the coverage is not covered for 12 months after the effective date. For 1 and 2 life groups, the pre-ex is 24/24.

5. The premium rates are determined using modified community rating, which means they can vary by age, gender, geographic area, tobacco-usage and family composition. There are no bottom to top limits on premiums.

6. Another key component of reform is that the premium format that carriers must use for the Standard and Basic plans is fixed. Appendix C contains a sample set of premiums for a Florida county (which is the smallest geographic area component allowed) showing the fixed format. A carrier can use a different county factor for each of the 67 counties and a multiplicative factor for tobacco-usage.

7. Many modified community rating structures do not include gender as a rating factor. To illustrate the effect of this, Appendix F contains the Florida premium format with gender removed. The number of cells in reduced from 48 to 24. Of greater importance the ratio of the age 60-64 premium to the under 30 premium is significantly reduced for males and increased for females. Most believe that these results are desirable.

Observations - Small Group Reforms

1. Premium Comparisons: As discussed in section 1, the current cost/plus method of determining premiums provides negative incentives for carriers to reduce costs. The 1993 small group legislation in Florida provides for standard benefits, standard premium format, guaranteed issue and modified community rating. These components allow for the development and distribution of premium comparisons that will allow the competitive marketplace to reduce premiums.

2. More Premium Comparisons: Appendix D is an actual comparison as prepared by the Department of Insurance. Each of the 13 carriers (A through M) shown is authorized to sell small group coverage in this county. An average individual and family premium is calculated for each carrier. Each carrier's average premium is compared to the average for all carriers to develop an index value. The index value demonstrates the carrier's premium level relative to all others offering coverage in the county. A value of 82 means the carrier's premiums are 18% less than the norm while 145 means that they are 45% more than the norm. Employers and employees can use this comparison to determine which carriers they want to receive quotes from.

3. Still More Premium Comparisons: The second step that the Department of Insurance will perform for a consumer is to calculate the actual premium for the group. Appendix E illustrates this calculation for a 7 person group. The coverage is shown together with the employee premium and dependent premium, if appropriate. The employer can use the premium comparison to choose 3 or more carriers with the premium calculation giving the actual premium for each carrier.

   This two step process performs several functions:

   a. Tends to overcome reluctance to contact an agent.

   b. Provides the employer with price comparisons across all carriers.

c. Provides the Department of Insurance with a further check that carriers are using the approved premiums, because the employer has a quote before contacting the carrier's representative, the agent.

d. For the first time to this writer's knowledge, real price comparison is present in health insurance. The department has received several reductions in premium rates in past months, which, in part, are a reaction to health care "mania", but are also as a result of these comparisons.

4. Guaranteed Issue: Carriers can not use medical condition of an applicant to deny coverage. The argument against guarantee issue is that consumers will wait until sick or injured to buy coverage and then have that treatment covered. The pre-existing condition provision helps eliminate this behavior, especially for 1 and 2 life groups where the pre-ex is 24months/24months. Another option for the carrier is to place a group or individual in the reinsurance pool. This pool has a $5,000 deductible and coinsurance above this amount. Many applicants are confused by the asking of medical questions to determine if they are to be placed in the pool. consumers believe that they will be denied coverage or that claims will not be paid. The Department of Insurance has formed a task force to develop risk adjusters which it is anticipated will provide a more satisfactory method of allocating the "antiselection" generated by guaranteed issue.

5. Results: A prime goal of health care reform is to provide coverage for the portion of Americans without it. The following table shows the number of people covered under Florida's small group policies at the end of each quarter since January 1, 1993.

DATE	NUMBER INSURED
3/31/93	11,769
6/30/93	32,543
9/30/93	118,830
12/31/93	162,855
3/31/94	218,847

6. Because 1 and 2 life groups were added to reform on April 15, 1994, a major jump in the numbers is expected for the second quarter of 1994. Over 60% of the sales were to consumers who did not have coverage. So, of the 2.7 million uninsured in Florida, coverage has been provided to over 130,000 by a program that is just getting started.

FLORIDA INSURANCE REFORMS - INDIVIDUAL INSURANCE

Background

As discussed in section 1, many individual health insurers use the following pattern to control the financial results under a policy form:

1. Only offer coverage to healthy people. The definition of healthy has become more restrictive in recent years, almost to the point where one can get coverage only if there is little or no chance of needing it.

2. Have the initial premiums fully reflect this healthy collection of insureds. The main emphasis is on a low initial premium to capture market share. Another reason for a low initial premium is that agent commissions are usually a larger percentage of the first year's premium than of the renewal year's premiums.

3. The policy is offered for sale for 1 to 3 years and then discontinued. This "closed block of business" is then not contaminated by new sales (with lower claims) so that as the claims increase, the premium will increase proportionally, allowing the company's profit to increase. It is critical to understand that with premiums determined by minimum loss ratios which leads to more or less automatic rate increases, the person paying the premium is at financial risk for increased claims under the block of business.

4. The four year rate increase comparison in Appendix A shows that companies differ in their effort to determine initial premiums that are adequate. This chart shows the five companies who sell the most individual major medical insurance in Florida. The average rate increases are based on rate filings made with the Department of Insurance for the companies largest block(s) of business. The medical component of the CPI increased about 8% per year for this same period.

5. The result of the these high renewal rate increases is that after a few years, healthy people drop the policy and begin a new one at a new low initial premium. Those who can not medically qualify for a new policy must continue this coverage or have no coverage. With a block that becomes more unhealthy with each passing year, claims are higher, so premiums are higher, so more healthy people leave, and so on. This is labeled a "death spiral".

6. Appendix B illustrates 4 premium patterns based on the level of increase in renewal years. The larger the renewal rate increase, the higher the tendency for insureds to drop their coverage and secure it elsewhere. This is reflected in the footnotes in that the percentage dropping their policies gets higher as the rate increases get larger. Based on the assumptions shown, the premium patterns will yield the same present value of revenue. D represents the general pattern for individual health insurance. The initial premium is attractive compared with pattern A, but the renewal year pattern is unacceptable to most consumers. Pattern A is representative of a community rating pattern where the underlying claim costs increase 5% per year. So, under modified community rating, the initial premium is higher than under "select and ultimate" pricing, but the renewal premiums are substantially lower. This is because everyone is paying a little more so that a few - the unhealthy - do not have to pay a great deal more.

Legislation: Actual and Proposed

1. The 1993 legislature in Florida passed a law which prohibits the most abusive form of the "select and ultimate" pricing described above. Insurers must now "pre-fund" (include in the initial premium) certain factors which effect the renewal premiums. Renewal rate increases in the last four years would have been in the 12-15% range had this reform been in place rather than the 20-45% shown in Appendix A.

2. The 1993 legislature also passed a bill that prohibits discontinuance of sales under a policy form to generate a closed block of business. This is a key factor leading to assessment spirals. If a carrier discontinues a policy form, then they can not offer a similar form for five years in Florida.

3. The Department of Insurance proposed to the legislature for the 1993 session the adoption of most of the same reforms for individuals as was adopted for small groups. Standard benefits, standard premium format and modified community rating were proposed. The possibility of an individual applicant "selecting against the company" (the propensity of an unhealthy person to seek coverage is greater than a healthy person) is greater than in the small group market. Therefore, the Department of Insurance proposed an annual open enrollment period and portability instead of guaranteed issue. These reforms were not adopted.

Product Design

As has been discussed above, the structure of health insurance policies has contributed to the need for reform. Please consider the following design ideas.

1. Health Maintenance Organizations (HMOs) are prepaid health plans that generally pay medical providers a fixed amount monthly to provide care. This structure is an improvement on the fee-for-service design of insurance products, but it lacks a direct incentive for the medical provider to reduce costs. Some would say that the incentive is for the provider to reduce care.

2. To financially reward the provider for improving care and reducing costs, consider development of health products that reimburse medical providers based on the degree of improvement in health condition of their covered group. More and more examples of medical providers finding innovative ways to provide quality care at low costs are becoming know. One example is the California physician who developed the alternative to invasive heart care by using diet, stress-reduction and exercise and achieved comparable results at a fraction of the cost. If the incentives are right, all will respond.

3. Develop health products that include coverage for the broad range of services so that consumers will not need to purchase supplemental coverages.

SUMMARY

Pattern

The pattern of individual and small group insurance is summarized below:

1. Premiums are determined by minimum loss ratios:

   a. Medical costs are "passed-through" to person paying premium.

   b. Cost/plus - increased profits by INCREASED claims.

2. Offer coverage only to healthy people.

3. Initial premiums only cover the initial (low) costs: push is to increase market share.

4. Offered the policy form for 1-3 years, then discontinue sales.

5. Claim costs escalate with no new (healthy) insureds.

6. Renewal premiums escalate (pass-through).

7. Healthy insureds drop policy, get coverage elsewhere.

8. Unhealthy can not get other coverage - must pay rapidly increasing premium or drop coverage.

9. Death spiral - number covered reduces rapidly.

Alternative

An alternative structure is summarized below:

1. Standard benefits

2. Standard premium format

3. Guarantee issue

4. Modified community rating

5. Portability

6. Premium comparisons

7. Product design

Four Year Rate Increase Comparison

Individual Major Medical Premiums

Company Name	Blue Cross	Golden Rule	Mutual of Omaha	Time	Union Bankers
Average Increase*	21%	45%	30%	20%	27%
A $1,000 Premium After 4 Years	$2,134	$4,490	$2,863	$2,086	$2,592

*Average Increase is based upon the last four years of the largest block(s) of major medical business.

Premiums rounded to nearest dollar.

Equivalent Premium Patterns

Year	A 5% Increase	B 10% Increase	C 20% Increase	D 30% Increase
1	$100	$96	$85	$78
2	$105	$106	$102	$101
3	$110	$116	$122	$132
4	$116	$128	$147	$171
5	$122	$141	$176	$223
6	$128	$155	$212	$290
7	$134	$170	$254	$376
8	$141	$187	$305	$489
9	$148	$206	$365	$636
10	$155	$226	$439	$827
11	$163	$249	$526	$1,075
12	$171	$274	$632	$1,398
13	$180	$301	$758	$1,817
14	$189	$331	$909	$2,362
15	$198	$365	$1,091	$3,071

Premiums rounded to nearest dollar.

*Assumptions

1. 5% Annual Interest Rate
2. Lapse Rates

	First Year	Additional Years
A	15	10
B	20	15
C	25	20
D	30	25

Standardized Rating

With Gender

Standard Plan

Hillsborough County

Insurer A							Healthpla Primary	Medicare Primary
	<30	**30-39**	**40-49**	**50-54**	**55-59**	**60-64**	**>64**	**>64**
Male Employee	$96	$121	$188	$280	$344	$443	$477	$184
Male Employee and Childre	$266	$280	$340	$432	$488	$425	$609	$317
Female Employee	$204	$204	$228	$277	$328	$407	$524	$163
Female Employee and Childr	$374	$363	$380	$429	$472	$540	$657	$296
Employee and Spouse	$300	$325	$416	$558	$672	$851	$1,001	$347
Family	$470	$484	$568	$709	$816	$983	$1,134	$480

Premiums rounded to nearest dollar.

Florida Premium Comparison

Health Maintenance Organizations

Hillsborough County	HMO Standard Plan			HMO Basic Plan		
COMPANY NAME	**Individual Average Premium**	**Family Average Premium**	**Index**	**Individual Average Premium**	**Family Average Premium**	**Index**
A	$168	$464	84	$168	$464	97
B	$306	$818	145	$290	$775	158
C	$185	$531	92	$157	$450	90
D	$173	$490	89	$147	$416	86
E	$159	$497	89	$136	$437	89
F	$177	$518	91	$153	$449	91
G	$167	$492	87	$145	$427	87
H	$204	$533	97	$168	$440	93
I	$158	$455	82	$124	$358	74
J	$299	$716	149	$257	$602	147
K	$182	$571	103	$157	$475	101
L	$181	$518	94	$142	$390	87
M	$199	$544	98	$178	$487	101

Premiums rounded to nearest dollar.

Census
Standard Plan

Insurer: Company A
Effective: July 1, 1994

Sex	Age	Coverage	Employee	Dependents
M	60-64	Spouse	$443	$408
F	50-54	Spouse	$277	$281
M	30-39	Employee Only	$121	$0
M	30-39	Employee Only	$121	$0
F	<29	Employee Only	$204	$0
M	<29	Employee Only	$96	$0
M	30-39	Spouse and Children	$121	$363
Totals:			$1,229	$812
Employees and Dependents:				$2,041

Premiums rounded to nearest dollar.

Standardized Rating

Without Gender

Standard Plan

Hillsborough County

Insurer A	<30	30-39	40-49	50-54	55-59	60-64	Healthplan Primary >64	Medicare Primary >64
Employee	$150	$163	$208	$279	$336	$425	$501	$174
Employee and Children	$320	$322	$360	$431	$480	$483	$633	$307
Employee and Spouse	$300	$325	$416	$558	$672	$851	$1,001	$347
Family	$470	$484	$568	$709	$816	$983	$1,134	$480

Premiums rounded to nearest dollar.

Department of Insurance

Health Insurance Benefits Plan

	HMO		Indemnity/PPO/EPO	
	Basic	**Standard**	**Basic**	**Standard**
I. EXPENSES A. Deductible: (1) Individual	None	None	$500	$250 and $500
(2) Family	None	None	$1500	$750 and $1500
B. Coinsurance	Not applicable	Not applicable	As specified	As specified
C. Copayments	As specified	As specified	As specified	As specified
D. Maximum Out-of-Pocket	200% of annual premium	200% of annual premium	$4,800/$9,600	$2,000/$4,000
E. Maximum Lifetime Benefit	200% of annual premium	200% of annual premium	$500,000	$1,000,000
II. INPATIENT HOSPITAL SERVICES	$250 copay/day, days 1-5, balance covered	$100 copay/day, days 1-5, balance covered	60/40 coinsurance	80/20 coinsurance
A. Health Care Provider Services	Covered	Covered	60/40 coinsurance	80/20 coinsurance
B. Maternity Services: (1) Physician/ Midwife	Covered	Covered	60/40 coninsurance	80/20 coinsurance
(2) 24-hour Admission & Discharge for Childbirth	Not applicable	Not applicable	Not applicable	Not applicable
(3) Free-Standing Birth Center	Birth centers are covered the same as hospital care	Birth centers are covered the same as hospital care	Birth centers are covered the same as hospital care	Birth centers are covered the same as hospital care
C. Transplant Coverage	Not covered	$100,000 lifetime maximum	Not covered	80/20 coinsurance, $100,000 lifetime maximum

	HMO		Indemnity/PPO/EPO	
	Basic	**Standard**	**Basic**	**Standard**
III. EMERGENCY CARE SERVICES A. Emergency Room	$100 copay/visit	$100 copay/visit	60/40 coinsurance, $50 copay	80/20 coinsurance, $50 copay
B. Ambulance	$50 copay	$25	60/40 coinsurance	80/20 coinsurance
IV. OUTPATIENT SERVICES A. Surgical Care in Outpatient Hospital Department	$100 copay/visit	$50 copay/visit	60/40 coinsurance	80/20 coinsurance
B. Surgical Care in Outpatient Health Care Provider Facility	$100 copay	$50 copay/visit	60/40 coinsurance	80/20 coinsurance
C. Non-Surgical Care in Ambulatory Surgical Center	No copayment, balance covered	No copayment, balance covered	60/40 coinsurance	80/20 coinsurance
D. Health Care Provider Office Visit	$10 copay/visit	$10 copay/visit	60/40 coinsurance	80/20 coinsurance
E. Specialist Office Visit	$20 copay/visit	$10 copay/visit	60/40 coinsurance	80/20 coinsurance
F. Surgical Care in Health Care Provider Office	$50 copay/visit	$25 copay/visit	60/40 coinsurance	80/20 coinsurance
G. Non-Surgical Spine & Back Disorder Treatment	$20 copay/visit (10 visits/CY)	$10 copay/visit (10 visits/CY)	60/40 coinsurance (10 visits/CY)	80/20 coinsurance (10 visits/CY)
H. Outpatient Rehabilitative Services	$20 copay/ session (10 sessions/CY)	$10 copay/ session (10 sessions/CY)	60/40 coinsurance (10 sessions/CY)	80/20 coinsurance (10 sessions/CY)
V. PRESCRIPTION DRUGS	Not covered	$7/ prescription or refill (generics only)	Not covered	$7/ prescription or refill (generics only)
VI. HOME HEALTH SERVICES	Covered up to 60 visits/CY (in lieu of hospital)	Covered up to 60 visits/CY (in lieu of hospital)	60/40 coinsurance; 60 visits/CY, #3,600/CY (in lieu of hospital)	80/20 coinsurance; 60 visits/CY, $3,600/CY (in lieu of hospital)

	HMO		Indemnity/PPO/EPO	
	Basic	**Standard**	**Basic**	**Standard**
VII. SKILLED NURSING FACILITY	Covered; lifetime maximum of 100 days (in lieu of hospital)	Covered; lifetime maximum of 100 days (in lieu of hospital)	60/40 coinsurance; lifetime maximum of 100 days (in lieu of hospital)	80/20 coinsurance; lifetime maximum of 100 days (in lieu of hospital)
VIII. HOSPICE	Covered (in lieu of hospital)	Covered (in lieu of hospital)	60/40 coinsurance (in lieu of hospital)	80/20 coinsurance (in lieu of hospital)
IX. PRIVATE DUTY NURSING	Not covered	Not covered	Not covered	Not covered
X. DURABLE MEDICAL EQUIPMENT & ORTHOTICS & PROSTHETICS	Covered	Covered	60/40 coinsurance	80/20 coinsurance
XI. X-RAY, LABORATORY & DIAGNOSTIC SERVICES	Covered	Covered	60/40 coinsurance	80/20 coinsurance
XII. MENTAL HEALTH SERVICES A. Inpatient Services	$250 copay/day (limit of 5 days/CY)	$100 copay/day (limit of 10 days/CY)	60/40 coinsurance (limit of 5 days/CY)	80/20 coinsurance (limit of 10 days/CY)
B. Residential Services	Not covered	Not covered	Not covered	Not covered
C. Intensive Non-Residential Servies	Not covered	Not covered	Not covered	Not covered
D. Outpatient Services	$20 copay per visit (limit of 10 visits per CY), maximum reimbursement of $50 per visit	$10 copay per visit (limit of 20 visits per CY), maximum reimbursement of $50 per visit	60/40 coinsurance (limit of 10 visits per CY and $50 per visit), maximum reimbursement of $50 per visit	80/20 coinsurance (limit of 20 visits per CY and $50 per visit), maximum reimbursement of $50 per visit
XIII. Preventative & Education Services	Preventative Medical & Reproductive Care is subject to $150 CY maximum benefit	Preventative Medical & Reproductive Care is subject to $150 CY maximum benefit	Preventative Medical & Reproductive Care is subject to $150 CY maximum benefit	Preventative Medical & Reproductive Care is subject to $150 CY maximum benefit

	HMO		Indemnity/PPO/EPO	
	Basic	**Standard**	**Basic**	**Standard**
A. Annual Physical & Reproductive Exam	$25 copay per exam	$25 copay per exam	60/40 coinsurance	80/20 coinsurance
B. Health Assessment Exam	See Annual Physical and Reproductive Exam	See Annual Physical and Reproductive Exam	See Annual Physical and Reproductive Exam	See Annual Physical and Reproductive Exam
C. Child Health Supervision	Covered (periodicity specified in Florida law)	Covered (periodicity specified in Florida law)	Pre-deductible, 60/40 coninsurance	Pre-deductible, 80/20 coinsurance
D. Contraceptives: (1) Oral	$8/prescription or refill	$8/prescription or refill	60/40 coinsurance	80/20 coinsurance
(2) Contraceptive devices and implants	$100 copay	$50 copay	60/40 coinsurance	80/20 coinsurance
E. Prenatal & Postnatal Care	$10 copay/visit	$10 copay/visit	60/40 coinsurance	80/20 coinsurance
F. Screening exams	Covered as part of annual physical/reproductive exam	Covered as part of annual physical/reproductive exam	Covered as part of annual physical/reproductive exam	Covered as part of annual physical/reproductive exam
G. Vision Services (1) Eye exams (adult and child)	Vision screening by primary care provider covered as part of $150 benefit allowance	Vision screening by primary care provider covered as part of $150 benefit allowance	Vision screening by primary care provider covered as part of $150 benefit allowance	Vision screening by primary care provider covered as part of $150 benefit allowance
(2) Purchase or fitting of eyeglasses	Not covered	Not covered	Not covered	Not covered
H. Hearing Services: (1) Hearing Exams (adult and child)	Hearing screening by primary care provider covered as part of $150 benefit allowance	Hearing screening by primary care provider covered as part of $150 benefit allowance	Hearing screening by primary care provider covered as part of $150 benefit allowance	Hearing screening by primary care provider covered as part of $150 benefit allowance
(2) Purchase or fitting of hearing aids	Not covered	Not covered	Not covered	Not covered

Mr. DINGELL. Thank you, Mr. Foley.
Mr. Curiale.
Mr. Curiale, you have been before the committee a number of times. You have always been helpful, we have always enjoyed your testimony, and we have always found we have learned a great deal from your assistance. We thank you for being here today.

TESTIMONY OF SALVATORE R. CURIALE

Mr. CURIALE. Thank you, Mr. Chairman. It is a pleasure to be here.

I thank you for the opportunity to talk about what New York has done to try and reform the small group and individual health insurance marketplace. I also appreciate the opportunity perhaps to refute some of the statements that are being made and bandied about, particularly in Washington about New York's reforms that they have been a failure, which, in my view, is a desperate attempt by the HIAA and its member companies like Golden Rule, desperate attempt to prevent those reforms to be enacted in other States and certainly even on a national basis.

In fact, those reforms have been very successful in creating a fairer, more equitable health insurance marketplace in New York, and in making meaningful health insurance available to more people at more affordable rates, especially when they need that insurance.

I would like to say at the outset that we in New York believe that mandatory universal coverage is important and should be accomplished. It is important because that is the only way that these health insurance reforms can operate at the optimal level that they should operate at.

I am saying that because what is happening is that those that are advocating the universal coverage nationally and even in certain States, have been saying that New York's insurance reforms are a failure. I do not want my efforts here to show you and others that New York is in fact doing a good job and in fact accomplishing a great deal to hamper the efforts by those who are trying to accomplish universal coverage.

What I am saying is that you need universal coverage, but even without universal coverage, if that should not be enacted on a Federal basis, that these reforms work and they are important. So having said that, I would like to say that our experience in New York is very much like Vermont's and Florida's. Unlike Vermont's the numbers are much larger, that is about the only difference.

What we did in New York—I have had the misfortune, I think, of being superintendent of insurance since 1990, and I have been prey to the Chinese curse or blessing of being superintendent of insurance during interesting times, whether it was the life insurance crisis or the health insurance crisis or catastrophes like hurricanes, et cetera, it seems that I have had it all in New York, and it is nice always to have as your hometown papers, the Wall Street Journal, the New York Times, and Newsday, not to mention the Daily News and the New York Post. I don't want to get into trouble. The Long Island Press is no longer with us, so I am OK.

What we did in 1992 was we enacted community rating and open enrollment for small group and individual health insurance, and as

others have described what that simply means is that if you are an insurance company and you are going to be in the small group or individual marketplace, you have got to take everybody, that is open enrollment. Guaranteed issue is another way to talk about it, and if you are going to rate them, you can't discriminate on the basis of their age, their sex, their occupation or their previous health status. You have got to rate everybody that is in a given geographic territory that has the same contract the same.

We also provided that you would have portability of your "preexisting condition" clause. That meant that naturally there is a preexisting condition clause because you don't want to have people remain uninsured until they get sick and then go into the system. That is counterproductive for everybody.

You want people in the system from the beginning, paying whether they are healthy or not, so that you can support others that are unhealthy and that are incurring costs. But once you are in the system and once you are insured, the portability of the preexisting condition clause is important because it allows you to say, well, I have waited my 9 months or my 1 year, now I am changing employers, and I shouldn't have to wait another 9 months because my employer, my new employer is insured with a different insurance company, and that has been something that has been very, very popular and universally acclaimed.

We also put in a risk adjustment mechanism which is very important which adjusts the premiums that are paid to different insurance companies based upon their demographics, their age mix, and sex mix which actuaries tell us is predictive of what your ultimate health care costs are going to be, and also on the basis of specified medical conditions which tend to be more expensive, medical conditions like neonatal situations, like ventilator dependence, like AIDS, like transplants.

It is very important in order to understand the impact of the law and how important the changes were to understand why we changed them and what the situation was immediately preceding our changes.

In New York, in the early 1990's, I would say 1991, particularly 1992, we had a crisis in small group and individual health insurance. People were being priced out of health insurance coverage at times when they needed it most.

The largest health insurance carrier in the State, Empire Blue Cross-Blue Shield—which had practiced open enrollment and community rating, had given meaningful coverages to people, low deductible, major medical coverages to everybody no matter what your illnesses were, no matter what your past history was, no matter what your age was—was rapidly deteriorating financially. That was the situation in New York in the 1990's, and it had changed rapidly because in the 1960's and the 1970's, everything was fine in New York and probably fine throughout the rest of the country.

In New York, what we had was for small groups and individuals we had large well-balanced pools which were written by the Blues. They had lots of younger, healthy people in there with the older, sicker people supporting the claims of the older, sicker people.

You had the law of large numbers working properly. All insurance is based on the law of large numbers. If you get together a

thousand people, you can expect 750 of them not to have very many claims.

They pay premiums, they absorb the costs of those maybe a hundred people that are going to have really expensive claims, and those other or so that have moderate claims, and you have insurance as it is supposed to work.

What happened was that as health care costs began to get higher and higher, a few companies, niche players as we call them, determined that it would be like shooting fish in a barrel to make a whole lot of money in the health insurance field. All they had to do was concentrate on small groups and individuals and underwrite carefully to "risk select" rather than "risk spread," to take only healthy people, people that they determined would not cost them a lot of money, would not have a lot of claims, to give them low rates, low rates, because it was easy to give them low rates since they weren't going to be paying very many claims, to give them good claim services, better claim services than the Blues because they didn't have any claims.

You can give great claim services, you can shadow price, you can charge a little bit lower, you can charge these low prices because you are not getting any claims.

What did we have as a result of all this? Well, what we had was a systematic stripping of the large well-balanced community-rated pools of the Blues.

I know the commercial carriers object to the term "cherry-picking." They say: We didn't go after these policyholders, we didn't take them away from Blue Cross-Blue Shield, we didn't take them away from Empire. But rather than taking them away, sometimes what I use when I argue with these executives, with these CEO's of these commercial insurers, I say: Well, if you didn't engage in "cherry-picking," what you engaged in was "cherry-catching." Because what would naturally and logically happen with any group of people like this, if you are in a pool of people that is being community rated and you are absorbing all these costs, and all of a sudden somebody comes in and offers you a lower rate because you qualify, because you are 25 years old or 30 years old and you have no previous health claims history, and nobody in your family has had a heart attack or cancer, and all of a sudden, somebody is offering you this lower premium, you are going to go. You are going to go, you are going to take advantage of this policy, which, in fact, is ice in the winter. Because those low rates and that coverage is not going to exist when in fact you need it.

When, in fact, something does go wrong, you are going to take it and you are going to take it quickly, and then when you turn from being a "cherry" into a "prune," perhaps because something goes wrong, because you get married. And in spite of the fact that you are 28 years old, you have a child with diabetes or some child that is not perfect, all of a sudden you become a "prune," and you know what?

The commercial carrier bounces your rate up and sticks you back with Empire Blue Cross-Blue Shield or some other Blue Cross plan that will take you, and then you will cost them money. That is what was happening in New York. Empire Blue Cross-Blue Shield,

between the years of 1991 and 1993, lost $400 million plus on its community-rated pools, $400 million plus.

A lot has been made of their mismanagement, and they have been mismanaged in many areas. There have been abuses. But the reason Empire Blue Cross-Blue Shield's financial condition deteriorated was because they were taking everyone in the 26 counties of New York, that are the most difficult health insurance counties in the country, they were insuring elderly people, they were insuring hemophiliacs who had gotten AIDS because of blood transfusions, people with multiple sclerosis, people with cancer, they were insuring all these people with meaningful, low deductible, major medical policies, while the commercial health insurers were refusing to cover these people or were taking these people with exclusions or were bouncing them out as soon as something went wrong.

That was the situation in New York, it was the situation in Vermont, it was the situation in Florida, it is probably the situation all over this country, and it particularly applies with individuals and small groups who do not have the benefit of large numbers.

Incidentally, it is happening with regard to large groups, too, because the health insurers are finding a way to bounce sick people, risky people out of large groups by offering new contracts periodically to other people in those groups who qualify, and creating the "death spiral" that Tom Foley talked about, even with regard to large groups.

So what did we do in New York? In New York, what we did was say if you want to be in this marketplace, if you want to do health insurance on a small group basis, you have got to take everybody, you have got to rate everybody the same.

And has it been successful? It certainly has been successful.

What we have seen in New York, in spite of the dire predictions of the HIAA and companies like Golden Rule, is that companies that wrote meaningfully in the small group marketplace did not leave the system—Guardian stayed, Chubb stayed, there are at least 18 or 19 companies writing small group health insurance in New York State right now.

They are writing on an open-enrollment, community-rated basis. Their loss ratios have gone up, no doubt about it. The average age of the people they cover have gone up. That was the whole purpose of community rating and open enrollment.

We don't like loss ratios around 60. We don't have any loss ratios around 40. That is unconscionable. It is unconscionable for a company to take a dollar of premium and to devote 40 cents of that premium to paying health care claims and 60 cents of that premium to paying expenses, commissions, and profits. That cannot be allowed to continue.

The loss ratios of commercial companies should be somewhere around 70 percent; not-for-profit companies should be somewhere around 90 percent, not 150 or 180 percent for not-for-profit companies and 40 percent for commercial carriers.

What has happened in New York? Well, in New York we have a very viable, small group marketplace. There is competition. The rates went up for younger people, no doubt about it.

Those 25-year-olds screamed like crazy when their rates went up 170 percent. Boy, those percentages are really bandied about by the HIAA and carriers like Golden Rule.

But what is 170 percent? 170 percent is going from $100 to $270. At the same time somebody at $600 is going down to $400.

Well, that is only 33⅓ percent reduction. Well, gees, 170 percent against 33⅓, that is terrible. It is not terrible. It is there. It is the same kind of dollars.

And you know what? Those younger people are going to get older. Sooner or later they are going to be high-risk people.

You have only two types of people in health insurance. You have high-risk people, and those that will become high-risk people if only because of the passage of time, and a lot of them are going to cross that line a lot sooner than they think.

The complaints from the younger people, I appreciate those complaints, they would rather use that money to buy a stereo or even perhaps a new Camaro, and that is not a bad thing, Mr. Chairman, I think new Camaros and new Firebirds, et cetera, should be purchased. But frankly, Mr. Chairman, what they are doing is they are making a choice, and they are making a foolish choice if they are choosing to be uninsured.

What they had as, I said before, was "ice in the winter." It was an illusion, it was an inexpensive policy for a worthless product, something that was not going to be there when they really needed it.

Instead, what we need to have is health insurance for people that will be there for all times. We certainly do need universal coverage.

We need more things in New York. We have begun not modestly, I think we have begun very aggressively, but we would welcome universal coverage and a financing mechanism, one that is fair and equitable to make sure that we have a sealed system so nobody leaks out of the system.

We are depending upon the Federal Government to give us that. We need all-markets legislation, because we have problems in New York. In New York when we changed the law, we said that HMO's had to write individuals. Individuals are people who don't buy insurance in the context of a group, they buy it directly from the insurance company.

They tend to be sicker people. They have lost their jobs perhaps, they have been excluded from other groups, they have diseases like MS, like AIDS, like cancer, et cetera, and they are more expensive.

We could not politically require, we couldn't get it passed that all commercial insurers who are in indemnity insurance had to write individuals, but HMO's do have to write them. The individuals in New York State are all insured with Empire Blue Cross-Blue Shield or the other Blues and their rates are going up.

We are trying to get an all-markets bill that would require all health insurers, even those that are just in the large group business, to somehow share the burden of individuals. We want standardized benefit packages, we are working on that.

The reason why you need a standardized benefit package, Mr. Chairman and Members of the subcommittee, is that you have to prevent back-door underwriting. You have to prevent health insurers from offering only those kinds of coverages that are attractive

to healthy people, coverages with very high deductibles, coverages that do not provide drug coverage, and therefore you won't get any AIDS people. You have got to require everybody to offer a minimum standard policy, you have got to decide what those minimums would be. That is relevant to cost control for sure, but you have got to provide them.

One other thing I might say, we have this risk-adjustment mechanism. It is very important. It is important because you have got to counter the argument of the health insurers that say that if we write everyone and we community rate, then we are subject to adverse selection.

We have said, well, if you have a risk-adjustment mechanism that adjusts for your demographics, if you have older people that suddenly come into your company or sicker people with all these different special medical conditions, specified medical conditions, then we are going to siphon more money from those companies that have younger people to you, so you are going to be OK.

We are also going to prevent you from marketing just to younger people, from complying with the law on its face but not complying with the spirit of the law because you have got your application office on the 55th floor with no elevator and no elderly people can get up there and because all your commercials have people that are only 30 years of age that are sailing and playing tennis and doing different things, and frankly, you don't want older, sicker people, so we have this risk-adjustment mechanism which will work.

We are having problems with ERISA, we are being sued by the HMO's, we are being sued by the commercial insurers who are saying that, well, you know, we insure basically employer-employee groups, and we really can't take money from them because that would violate ERISA.

If we do not have these reforms on a national basis, Mr. Chairman, if we don't have them right away, we need, the States need some relief from you, from Congress so that we can spread the risk of health, high health insurance costs and health care costs equally equitably to everyone in the broadest possible fashion, and without interference from ERISA.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Curiale follows:]

STATEMENT

of

SALVATORE R. CURIALE

INDIVIDUAL AND SMALL GROUP HEALTH INSURANCE REFORM IN NEW YORK STATE

Mr. Chairman and Committee Members: I am Salvatore R. Curiale, Superintendent of Insurance for the State of New York. Thank you for your invitation to testify today concerning assertions made by the Golden Rule Insurance Company, the Health Insurance Association of America, the Crain's business journal, and others that health insurance reform in New York State has been a failure. We categorically disagree. In fact, we are quite proud of our reform efforts in New York State, reform efforts that have resulted in a fairer, more stable and more accessible health insurance system which has also allowed an increased number of older and ill individuals to obtain coverage at substantially more modest rates. Furthermore, it was the aggressive underwriting practices of the type practiced by Golden Rule which led to people being excluded from the system and rates being jacked up by discriminating against policyholders and potential policyholders based on such things as pre-existing conditions, propensity to become ill, and age.

Open Enrollment and Community Rating for Individuals and Small Groups

In July of 1992 open enrollment and community rating legislation was enacted in New York.

The major provisions of that legislation included the following:

-- Any health insurer offering an individual or small group contract in New York was required to accept all applicants.

-- All individual and small group health insurance contracts were required to be community rated, that is, all persons with that contract pay the same rate without regard to age, sex, health status or occupation.

-- All HMOs in the state were required to offer individual contracts.

-- Persons with health insurance coverage who change jobs must be credited with the time covered under their prior contract when calculating the pre-existing condition limitation.

-- A risk adjustment mechanism among insurers was authorized to assure market stabilization.

Issues Leading to Legislative Reform

What prompted New York to embark on a major and controversial effort to change the health insurance financing system in New York as it existed in the early 1990s?

In the 1960s and 1970s most small groups and individuals were able to obtain health insurance coverage through regional Blue Cross/Blue Shield plans or commercial carriers. Health care expenditures grew rather modestly over this time and premiums remained relatively affordable for all participants. In the 1980s, health care costs skyrocketed and commercial health insurance companies began to screen applicants more closely in an effort to avoid the worst risks. At the same time, the largest Blue Cross/Blue Shield plan in New York was expanding its open enrollment policy, making available major medical coverage without underwriting.

Dramatic annual increases in hospital and medical costs during

this time were convincing many small employers to seek out lower-cost alternatives. Employee groups that contained the better risks, i.e., the healthier individuals, were able to achieve savings through the commercial health insurance companies which could pick and choose the healthiest and youngest groups.

New York is one state in which Blue Cross/Blue Shield plans have retained their traditional role as health insurers of last resort, thus it was these non-profit insurers that were badly hurt when their best risks began to sign on with lower-price competitors who carefully selected only lower risk customers. Since Blue Cross/Blue Shield plans rely on the experience of their entire community of risks in determining rates for individuals and small groups their premiums began to accelerate as their pools of risks deteriorated. Companies that practiced both open enrollment (i.e., accepting all applicants without regard to medical condition usually with a waiting period for claims that result from pre-existing conditions) and community rating were trapped in a spiral of ever-escalating premiums. As premiums rose, more and more healthy customers abandoned the fold, which meant further rate hikes.

In our review of commercial carrier underwriting rules we found that these carriers generally had a very long list of blacklisted or restricted industries and occupations, that is, small businesses that are absolutely rejected by the insurer. They included such businesses as farms, wrecking and demolition work, restaurants, policemen and firemen, florists and liquor stores, orchestras, actors and other entertainment groups, barber shops and beauty shops, hotels/motels and transportation industries such as taxicabs and trucking and many more.

The list of restricted industries and occupations by commercial insurers grew, leaving Blue Cross as the only option for many small groups. The poorer risks and those without leverage in the marketplace were able to obtain coverage only through the Blue Cross/Blue Shield plans and were required to pay higher and higher premium rates.

As we saw a rise in the number of uninsured persons in the state; as the complaints increased by individuals and small businesses that they were being priced out of health insurance coverage; as we saw the community rated pools of Blue Cross/Blue Shield being significantly reduced in number and becoming more costly; and as we saw more individuals and members of small groups rejected for coverage by some insurers, it became obvious that there was a need to change the existing system.

We believed that the problems we were faced with in the individual and small group market appeared to be caused primarily by allowing the underwriting of health insurance risks and by the existing statutory authority which allowed community rating and experience rating to exist as competing rating methodologies.

We felt the fundamental change necessary in our approach to health insurance protection for individuals and small groups was that less effort should be expended keeping people out of the system through underwriting and rating barriers and more effort expended in bringing people into the system and doing a better job of managing their care and protecting them from the instability that results from widely fluctuating premium rate increases.

This fundamental change in approach to health insurance protection for individuals and small groups could best be achieved through a change in the insurance system which required that these risks be community rated on an open enrollment basis subject to rate approval by the Insurance Department.

Impact of Reforms

In analyzing and evaluating the enactment of the community rating/open enrollment law in New York, its implementation and the resulting changes in the marketplace, we have the following observations and comments:

-- The availability of health insurance coverage from all types of insurers (commercials, HMOs and non-profits) eliminated the Blue Cross Plans as the insurer of last resort in New York. Anyone, regardless of health status or occupation, can now obtain health insurance coverage at a community rate.

-- It had been predicted that open enrollment and community rating would cause commercial insurers to leave the health insurance market. That fear was unfounded. A few commercial insurers left the individual and small group market, however, they were insignificant writers. All of the major small group health insurance writers remained in the small group market.

-- Community rating did cause premium rates to increase for younger insureds, however, about 60% of the persons affected by the change in rates received rate decreases or increases no greater than 20%, including trend. Some carriers combined normal rate increases with the change to community rating and used community rating as the scapegoat for consumer complaints about increases.

-- The requirement to provide coverage on an open enrollment basis and community rating of individual and small group health insurance policies accelerated the change by insurers to managed care products.

-- Consumers were particularly pleased with the "portability provisions" in the law which allowed them to change jobs without the imposition of a new pre existing condition limitation.

-- Empire Blue Cross and Blue Shield, which was in the midst of well-publicized management problems, lost considerable market share just prior to and subsequent to passage of the community rating/open enrollment legislation.

-- There was a considerable number of telephone inquiries (900+ phone calls in one week in mid-March, 1993) just prior to and immediately subsequent to implementation of the legislation. In hindsight, staggered implementation of the community rating requirement, such as at time of renewal, would have made the systemic change smoother.

-- The initial community rates filed by some commercial insurers with the Insurance Department for use on April 1, 1993, were reduced shortly after April, 1993, because of the competitive small group market. In combination with regulatory pressure to reduce rates for April 1 approval, a strong market dynamic quickly developed.

-- The implementation of the law, including promulgation of regulations and necessary regulatory determinations based on interpretation of the law, was difficult and confrontational and has led to numerous lawsuits.

-- The community rating/open enrollment legislation did not require that all insurers participate in all markets. Only HMOs are required by law to be in the individual market, although they have few individual insureds, and as a result, Blue Cross plans dominate the individual market and commercial insurers continue to avoid the individual business.

-- The implementation of a risk adjustment mechanism through establishment of demographic and specified medical conditions pools presents an ongoing challenge which requires continuous oversight and data collection with pools operational in seven geographic regions of the state.

-- More needs to be done to reform the health insurance system in New York, including standard benefit legislation, "all markets" legislation and implementation of standard claim form legislation. Standard benefits and "all markets" legislation have been proposed this year and implementation of standard claim forms legislation will also take place this year. Obviously we would also welcome federal legislation requiring universal coverage and an equitable financing system.

In general, the community rating/open enrollment legislation has made individual and small group health insurance more available to people in New York and premium rates are more stable. In the small group health insurance market the law is working well as small groups now have greater choice of insurance plans and insurers must compete on the bases of competitive price and management of care rather than on risk selection and different rating methodologies. The individual market continues to present the problem of affordability for many but this situation should be helped in part by the risk adjustment mechanism and by an "all markets" bill which would require that insurers operating in the group market subsidize the individual market.

There has been particular interest in the New York experience with regard to the scope of the reform, our decision to require pure community rating, our establishment of rating areas and our development of a risk adjustment mechanism.

Why "Pure" Community Rating

At the time of enactment of the open enrollment/community rating legislation in New York all Blue Cross/Blue Shield plans in the state were community rating their individual and small group business. In addition, all HMOs were required to community rate all of their business. A change to something less than pure community rating would have been a step backward. So-called modified community rating appears to be a recent development and is really not community rating, which had traditionally meant that age and sex would be eliminated as rating factors.

The selection of groups of 50 or less persons to be affected by the legislation was based on a number of considerations including:

-- many insurers considered groups of 50 or fewer persons as small groups.

-- those groups most in need of assistance in obtaining and maintaining health insurance coverage were the smaller groups.

— being too ambitious may have caused more political opposition, and

— if it was desirable to expand the groups affected by the law that could be done at a later time.

The New York Law and regulations make a distinction between permissible geographic rating areas for insurers and pooling areas under the risk adjustment mechanism. Individual insurers must charge the same rate to all policyholders having the same contract without regard to age, sex, health status or occupation, however, different premium rates are permitted for different geographic regions not smaller than a single county, provided the regions do not appear to contain configurations designed to avoid or segregate particular areas within a county. Individual insurers thus determine their own geographic regions for the purpose of rating within these constraints.

Risk Adjustment Mechanism

For the purpose of risk adjustment pooling there are seven broad geographic regions established by the Insurance Department generally following the geographic rating areas used by the various Blue Cross/Blue Shield plans in the state.

The risk adjustment mechanism in New York established risk sharing pools for three reasons:

(1) To promote competition among insurers and HMOs on the bases of administrative efficiency and managed care effectiveness.

(2) To deter competition among insurers and HMOs on the basis of avoiding or terminating coverage of people whose health care costs are high.

(3) To encourage insurers and HMOs to enter, remain in, and compete vigorously in the small group and individual health insurance markets, by shielding them from the adverse financial consequences of insuring a disproportionate share of people whose health care costs are high.

Insurance Department Regulation 146 seeks to achieve these purposes by establishing two types of pooling:

(1) A portion of the cost of specified high-cost medical conditions (transplants, low-birth-weight babies, AIDS and conditions leading to ventilator dependency) is pooled among all insurers and HMOs. Through this type of pooling, all insurers and HMOs proportionately share a part of the cost of treating these conditions.

(2) The degree of health risk in each insurer's and each HMO's individual and small group business, as measured by the proportion of its business in broad age/sex (i.e., demographic) categories, is compared to the average degree of health risk for all insurers and HMOs. Insurers and HMOs which have a lower than average degree of health risk in their individual and small group business pay into the pool. Insurers and HMOs which have a higher than average degree of health risk in their individual and small group business collect from the pool. This type of pooling prevents insurers and HMOs from profiting by intentionally or unintentionally "skimming" the best risks; it also protects insurers and HMOs which don't "skim" by compensating them if they cover a disproportionate share of high risk people because of "skimming" by other insurers.

Regulation 146 established seven geographical regions in each of which there are three risk adjustment pools, as follows:

(1) A demographic pool for Medicare supplement business;

(2) A demographic pool for all of the non-Medicare supplement individual and small group (groups of 50 employees or less) medical expense policies subject to pooling; and

(3) A specified medical conditions (SMC) pool for non-Medicare supplement business.

Each demographic pool for a region uses demographics by age, sex and family status to generate an index called the Average Demographic Factor (ADF) for each carrier in that region. A Regional Demographic Factor (RDF) is calculated by taking the average of the ADFs for all carriers in that region. The regional demographic factor represents the average age/sex/family status for that region. Specifically, to focus on the age parameter, each carrier with a younger risk pool will pay and each carrier with an older risk pool will collect. The rationale for the age adjustment in the demographic pools is the recognition that morbidity increases by age and the risk selection that is present by age in a carrier's risk pool can be risk adjusted to eliminate, or at least significantly dampen, the variation among carriers by age.

Each SMC pool for a region collects a premium between $1.25 and $5.00 per individual and between $2.50 and $10.00 per family per quarter from each participating carrier. These premium variations reflect richness of benefits. The premiums fund the reimbursement of a fixed amount to each carrier which experiences a claim for any of four conditions: transplants, neonates, AIDS and ventilator dependents. The rationale for the SMC pool is to reimburse for aberrational catastrophic claims.

Both the demographic and SMC pools have both prospective and retrospective aspects to them. For example, carriers with younger demographic pools can load their premium rates to reflect anticipated pool contributions. The retrospective aspect of the demographic pools takes the form of an annual reconciliation (in May of each year) that "trues up" the expected demographics and claims to the actual experience.

The SMC pools also collect a premium from every carrier and then reimburse for the specified conditions: transplants, neonates, AIDS and ventilator dependents. Retrospective risk adjustment predominates for the SMC pools.

The SMC pools reimburse a fixed amount which has been set low enough to encourage managed care practices. If some carrier incurs less expense than the stipulated amount, then the actual expenses are substituted for the stipulated amount. Because the amounts are set much lower than required to reimburse the full expense for the condition, the pool has a managed care thrust, an incentive for the carrier to keep expenses or manage expenses down to the stipulated amount.

System development to implement the risk adjustment system was probably required by all carriers in order to extract the appropriate demographic data and, in some cases, perform the demographic calculations. In addition, the administrator of the pools (Alicare) had to develop some systems for administration and reporting, but was able to adapt some existing systems with relative ease.

With respect to the SMC pools, the data collection and submission at this point are minimal so that it is difficult to ascertain the necessary system development work. However, since the New York risk adjustment mechanism is relatively simple, it is not expected to be a major expense item in the larger scheme of things.

Administratively, the demographic pools are collecting money from and disbursing money to the various participating carriers. The calculations necessary for the demographic pools are done on worksheets designed and distributed by the New York State Insurance Department with the cooperation and assistance of its administrator, Alicare. Five quarterly collections and four disbursements have been made with a very limited number of problems.

The SMC pools have collected money, but distributed a limited amount to-date. For the most part, participating carriers have not as yet requested reimbursement. The delay in those requests is partially due to the newness of the pool and of the rules and procedures for obtaining reimbursement.

Legally, there have been several challenges to the pools by the New York HMO Conference and commercial insurers. For those HMOs participating in the lawsuit, payments into the pool have been put into an escrow account until a final determination is made by the courts. Therefore, disbursements have been reduced by the escrowed amounts. Again, pool payments are often a function of a younger risk pool, which is the result of past risk selection practices (including benefit design practices) that encouraged enrollment of younger risks and/or discouraged older risks.

CONCLUSION

New York's open enrollment and community rating legislation was designed to create a fairer, more stable and more accessible health insurance system. It has done that. It did not provide for universal coverage nor was it conceived as the ultimate solution to our health care financing woes. Most of us believed the system would be stabilized and that health insurance would be more available and more affordable for more people, especially those who need it. Nobody suggested that the changes would be painless or would reverse a five-year systemic rise in the ranks of the uninsured.

Looking at the experience of the first nine months of open enrollment/community rating leads me to the inescapable conclusion that New York's small group and individual health insurance market has indeed remained stable. While the number of people insured through individual contracts has decreased, enrollees in Medicare supplement and small group plans have actually increased. In fact, the increase in small group enrollees in New York State runs contrary to the national experience, where the percentage of workers covered by small firms (fewer than 100 workers) continues to decrease.

Although rate increases for a small number of young people were, on a percentage basis, quite high during the first few months of open enrollment, the policies they are now purchasing are a vast improvement over the pre-open enrollment ones. In the past, groups of young people could buy a piece of paper that promised them "coverage" for what appeared to be a low price, but provided no assurances that such coverage would remain at that price should they or one of their co-workers become seriously ill. Commercial insurers were providing "inexpensive" coverage to people who in all likelihood would never collect the benefits when they really needed them. When these people grew older or became ill, many commercial insurers turned their backs on them, leaving others to provide the necessary protection. I submit that even though these young people were paying fewer dollars for "coverage" prior to open enrollment/community rating, they were being overcharged. Under open enrollment/community rating, young people can be assured coverage will be in place when they need it most and, thanks to our portability provisions, they are now able to change jobs, even after serious illness strikes, without fear of losing valuable protections.

It should be noted that the rate hikes that were implemented as a result of our move to community rating were one-time adjustments. Future rate changes will be based on the experience of a contract's community pool and projections of future medical costs.

There are those who would argue that open enrollment/community rating won't work unless everyone is required to be covered. We would agree that the best open enrollment/community rating system would be one where all people are covered, however, even in the absence of universal coverage, we believe that open enrollment and community rating, particularly for individuals and small groups, is essential. The New York experience has shown that open enrollment/community rating applied to the current system can create a fairer, more stable and more accessible health insurance system, especially when that system includes a risk adjustment mechanism. The importance of the risk adjustment mechanism cannot be over-emphasized for it provides insurers protection from sudden shifts in the proportion of high risk persons they cover and prevents an insurer from obtaining a competitive advantage by avoiding or failing to insure a proportionate share of high risk persons. If we are unsuccessful in our legal defense of this risk adjustment mechanism which is being challenged on the basis of ERISA pre-emption we will need federal legislative assistance in order to continue essential market stabilization and risk spreading mechanisms.

In response to one commercial insurer that offered individual coverage in New York and complained that after one year of open enrollment/community rating it had seen the average age of their policyholders increase, there is an obvious answer. When open enrollment was introduced it was expected that commercial insurers that remained in the market would, by offering their policies to all comers, see an increase in the average age of their policyholders. That was the point of open enrollment/community rating -- spreading the older and sicker risks among all insurers. Moreover, the one commercial carrier that has complained the most about the loss of younger policyholders raised its metropolitan-area family deductible from $500 to $5,000 in April 1993 when open enrollment took effect. An increase of that magnitude would lead most policyholders, except the healthy and wealthy, to search for alternatives.

The argument by some commercial insurers that pure community rating penalizes the young insured because they pay the same rate as an older insured but use fewer hospital and medical services also requires a response. In our view any open enrollment/community rating system should be as inclusive as possible in order to bring down the overall costs for all participants. An ideal system would include within one community pool individuals, small groups and large groups, the young and the old, the healthy and the sick. Any so-called subsidy for seniors would presumably even out over time as the young people grow older. It should be noted that just about every health maintenance organization in the country uses community rates, yet nothing is heard from the commercial insurers about a "senior subsidy" under these contracts. The contention that community rating is unfair to the young is simply a smoke screen devised by the commercial carriers to preserve the system now in place in most other states which converts what should be an internal subsidy benefiting all policyholders into profits for the insurer.

We believe that the open enrollment and community rating legislation has rewarded New York residents with a number of significant benefits. As a result of the open enrollment mandate, New Yorkers can obtain comprehensive health insurance coverage from a number of insurers and HMOs without regard to their medical condition, their age or their occupation. Community rating has stabilized premium rates and rate increases. Insureds need not worry that one or two catastrophic claims will result in large rate increases. Further, restrictions on pre-existing condition limitations have afforded portability of coverage allowing New Yorkers the ability to change jobs or individual insurers or HMOs without being subject to new waiting periods for continuing medical problems.

We strongly endorse open enrollment and community rating, including an appropriate risk adjustment mechanism, all of which have had such a positive impact on the New York health insurance system. We also recognize, however, that additional changes are necessary to further address existing problems with the system. We look forward to working with State and Federal legislators and all interested parties to afford all of our citizens the opportunity to obtain and maintain comprehensive health insurance coverage at an affordable cost.

Mr. DINGELL. Mr. Curiale, the committee thanks you for a very powerful statement. We appreciate your assistance to us.

The next witness is the Honorable C. Jeanne Shaheen.

TESTIMONY OF C. JEANNE SHAHEEN

Ms. SHAHEEN. Thank you, Mr. Chairman and Members of the committee.

My name is Jeanne Shaheen, and I represent District 21 in the New Hampshire State Senate. I am delighted to hear the comments from New York and Vermont relative to how community rating has worked in those States. Having just gone through the battle of health insurance reform in New Hampshire and hearing the claims by HIAA and other commercial carriers, it is nice to know that we were right in New Hampshire and that they are wrong.

This session I was the prime sponsor of Senate Bill 711, the Small Employer Health Care Insurance Reform Act. The bill will take effect January 1, 1995, and it provides for community rating, forbids medical underwriting, ensures guaranteed issue, and eliminates preexisting conditions. The bill was designed to provide greater access to insurance coverage and more stable rates.

The community rating provisions of the bill are phased in over a 2-year period, with modifications for age allowed. In the second and all subsequent years, there can be a differential of 3 to 1 for age. However, no rates can increase more than 25 percent a year and all rates must be approved by the State's Commissioner of Insurance.

The legislation was supported by a broad coalition of people. The Governor who serves in the opposite party than I do, signed on, as well as his Commissioner of Health and Human Services. The legislative leaders in both houses supported it from both parties, and the three largest providers of health insurance in New Hampshire supported the legislation.

Of course, as you can imagine, Golden Rule did not support the legislation, and unlike the other members of the panel, I am really not going to address the technicalities of the legislation as much as I am my experience with Golden Rule.

Golden Rule writes about 0.14 percent of the premiums in the State of New Hampshire. That is a little over 1 percent of the insured population in the State. Information that we had from the insurance department for 1992, indicated that only 54 percent of their premiums went to pay direct health care costs. The rest went for overhead, administrative costs, the things that Superintendent Curiale indicated were unconscionable, and I would certainly agree with him.

The company, as you have heard, has captured this profitable market by cherry-picking and by refusing to insure people who are sick. From the very beginning, Golden Rule opposed the legislation that I sponsored, and they came in and testified in the Senate hearing on the bill and talked about the 170 percent rate increases in New York. And one of the things that they handed out to all of the members of the Senate panel was this article, which I believe you have in your packet, from the New York Daily News which was dated March 10, 1993. And when I pointed out to their lobbyist that the community rating in New York didn't even go into effect

until April 1 of that year, so that the 170 percent rate hikes in this article were just based on somebody's speculation about what was going to happen, her response to that was, well, we couldn't find any newspaper articles after the bill went into effect that talked about the high rate increases.

I would submit that speaks for itself. We didn't hear from Golden Rule again until several weeks before the legislation was due to be heard in the House.

Now, for those of you who don't know, New Hampshire has a 400-member House, it is very large, it is very easy on particularly technical issues like health insurance. To confuse the issue, they began to run a series of radio advertisements in the metropolitan areas of New Hampshire opposing the legislation and urging people to call their legislators.

They sent out letters to all of their policyholders and all of their brokers in the State, which included my favorite Daily News article as well as what I believe was deliberate misinformation about what the bill would do in New Hampshire. They indicated that in New York, nine carriers had left the State as a result of the community rating provisions.

In our conversations with the insurance department in New York they told us that was incorrect. They also indicated that if the bill passed, they wouldn't be able to set the rates in New Hampshire, the government was going to set the rates in New Hampshire.

Now, while our insurance commissioner does approve all rates, I would not say that he sets the rates. He certainly doesn't provide the numbers.

In response to the letter and the radio ads, I testified before the House Commerce Committee refuting Golden Rule's claims. I pointed out that I thought they were misrepresentations and that the only thing that Golden Rule was interested in was in changing the rule so that the gold could go to their bottom line.

About a week after I gave that testimony, I received a letter from someone who identified himself as the attorney for Golden Rule who took exception to my comments and warned me that the company might bring suit if I made such remarks outside of the legislative cocoon. He also copied that letter to the local reporter who covers the major newspaper in my legislative district.

I assume that his intent was to intimidate me. He was not successful. What I did was to immediately release that letter to the press and to the rest of the legislature in New Hampshire. Those tactics I think wound up hurting them in New Hampshire because people do not like to be threatened with lawsuit for pursuing legitimate public policy interests.

Finally, 2 days before the legislation was to be voted on in the House, which was the last hurdle before passage, Golden Rule, under the umbrella of a group called the Council for Affordable Insurance, held a press conference where they presented what they claimed to be was an objective report on what would happen in the State if this legislation passed.

It was done by Milliman and Robertson, and it purported to show that if the legislation passed, 47 percent of the people in New Hampshire would drop their insurance within the first year.

While under aggressive questioning from the media, they finally admitted that the person who, the actuary who actually did the model was one of the members of the Council for Affordable Insurance and that he had been contracted at a cost of $75,000 to develop this model and that the numbers that were used for New Hampshire were all suppositions, that if you changed the assumptions for that model, you would change the outcome of the report.

Golden Rule attempted to influence what happened in New Hampshire, and they very nearly succeeded. As you can imagine as a result of those tactics, we heard from hundreds of policyholders and constituents in the State who were very afraid of what the legislation was going to do.

One of the interesting things about that, though, is that it also produced a number of stories about Golden Rule and the unfairness of how they write their policies. You heard from Vermont about how they refused to cover certain parts of the body.

Well, we heard from one legislator whose son had had a foot injury when he was young, and they now cover him as a young adult but they don't cover anything below the knee on the right leg. We heard from another legislator who is a member of the House leadership who had been opposed to the bill until several weeks before he was due to vote on it when he was notified by Golden Rule—and this is somebody who I would say is heavy but certainly is not obese, is not overweight, had never been in the hospital, was in his early 30's, he was denied coverage by Golden Rule because they said he was too fat. He voted for the legislation.

As a legislator, I can understand the need for companies to protect their own self-interest and to oppose legislation that they feel is not in their interest. However, I am very troubled by the prospect that one company, Golden Rule, can come into a State like New Hampshire where they have a very small percentage of the market, where they can spend as much money as they choose to try and defeat legislation, to thwart the political will of the majority to further very narrow corporate interests.

I urge the subcommittee to consider appropriate measures to insure that the pursuit of private interests does not threaten or undermine the public good. That concludes my statement, Mr. Chairman.

[The prepared statement of Ms. Shaheen follows:]

Statement

of

Senator Jeanne Shaheen

Mr. Chairman and Members of the Subcommittee:

Good morning. My name is Jeanne Shaheen. I represent District 21 in the New Hampshire State Senate.

This session I was the prime sponsor of Senate Bill 711, the Small Employer Health Insurance Reform Act. The bill, which became law earlier this month, introduces community rating, forbids medical underwriting, ensures guaranteed issue, eliminates pre-existing conditions and limits waiting periods.

The community rating provisions of the bill are phased in over a two year period. Carriers are allowed to modify premiums for age with the maximum premium differential in the first year determined by a ration of 4 to 1.

In the second year and all subsequent years, the maximum differential is 3 to 1. Six age brackets are allowed but rate increases are limited to 25% per year. The only other modification to be allowed in community rating is the administrative cost of doing business with different group sizes. All rates must be approved by the state's Commissioner of Insurance.

The legislation was supported by those who together insure the majority of private individuals and small groups in New Hampshire as well as by organizations representing management and labor and associations representing health care providers. The bill was endorsed by the Governor and Commissioner of Health and Human Services and enjoyed bipartisan support in both houses of the legislature.

Nevertheless, the complexity of the bill required the thorough explanation and careful consideration which the legislative process of public hearings and work sessions ensures.

I respect the right of any firm, or industry, or interest or group to question, challenge and oppose legislation which they believe threatens their interests. Reconciling diverse and competing interests, as every legislator knows, is an essential part of the lawmaking process.

Golden Rule Insurance Company did not participate or contribute to the success of the process. Instead, they went to considerable lengths to pervert the process in what proved a vain effort to kill the legislation.

Golden Rule, a corporation registered in Illinois and headquartered in Indiana, wrote about one and a half percent of all health care policies in New Hampshire and returned only 54 percent of premiums paid in health care benefits in 1992. The company has captured this small but profitable market by so-called "cherry picking," one of the practices Senate Bill 711 was intended to curb.

Golden Rule expressed nothing but unqualified opposition to the bill from the outset. In February, when the bill was heard by the Senate Insurance Committee, the company testified that similar reform, especially community rating and guaranteed issue, led to rate increases of 170 percent in New York, citing a newspaper report which appeared before the reforms were implemented in support of their claim. In April the company repeated and embellished this claim in mailings to policyholders and brokers. The mailing stated that "When New York passed these reforms last year, the New York Department of Insurance approved rate increases for young families of 170%!" Furthermore, the letter stated that nine major carriers abandoned the small group and individual health insurance markets in New York, a claim refuted as false by the Director of the Life and Health Division of the Department of Insurance of the State of New York. Both claims were also made in radio advertisements broadcast in metropolitan areas in New Hampshire.

When the House Commerce, Small Business and Consumer Affairs Committee heard Senate Bill 711 in March I corrected the false claims made by Golden Rule in their testimony, mailings and broadcasts. I also issued a press release not only challenging the veracity of their claims but also the morality of their tactics.

On April 20, Golden Rule, in another mailing to policyholders and brokers, again encouraged opposition to the bill without, however, repeating the specific false statements made earlier. At the same time, I and other members of the Senate received a letter from Golden Rule which referred to "confusion...about the information given to policyholders" in the original letter. But, the second letter to policyholders and brokers neither repudiated nor corrected the claims of the first, although the company knew full well these claims were utterly false.

A week later, I received a letter from an attorney, Edgar R. Lantis of Indianapolis, Indiana, representing Golden Rule who informed me that my remarks before the House Commerce, Small Business and Consumer Affairs Committee, as reported in a local newspaper, were "false, malicious and defamatory" and "represent libel." His letter cited my statement that the company had "resorted to lies and half-truths" and another statement measuring the company's performance against the "golden rule." He warned me that the company might bring suit if I made such remarks outside the legislature. I responded by saying publicly that I would not be intimidated.

Finally, Golden Rule, under the umbrella of the Council for Affordable Insurance, staged a press conference to present a report prepared by Milliman & Robertson, Inc. which purported to show the impact of Senate Bill 711 on the number of uninsureds and the cost of insurance in New Hampshire. Presented as an independent, objective study, the report was, in fact, a theoretical model laced with questionable assumptions and yielding speculative conclusions. Only under aggressive questioning from the media was it conceded that Milliman & Robertson, Inc. were themselves members of the Council and that the Council commissioned the report at a cost of $75,000.

Golden Rule waged an expensive campaign against Senate Bill 711. State law (Revised Annotated Statutes, Chapter 15) requires that lobbyists register with the Secretary of State as well as disclose all fees and expenses. Only two lobbyists registered on behalf of Golden Rule prior to April 1, neither of whom signed the mailing to policyholders and brokers. Together they reported fees and expenses of little more than $2000. In light of the costs of direct mail and radio advertising as well as the report by Milliman & Robertson, none of which appear to be reflected in the company's disclosures, I have asked the Attorney General to determine if Golden Rule has violated the lobbying statutes.

Since my encounters with Golden Rule I have learned that this company's conduct in New Hampshire was in keeping with the ways it has pursued its interests elsewhere, including attempts to intimidate public officials. In New Hampshire, Golden Rule sowed fear and anxiety among citizens and lawmakers by knowingly and willfully misrepresenting a legislative measure which commanded widespread support among all those affected by it. And they nearly succeeded.

As a legislator and citizen, I am very troubled by the prospect that one company which has secured a market within a community where it has no other presence --- no property and no payroll --- may thwart the political will of that community to further narrow corporate interests. Frankly, I believe the kind of corporate citizenship practiced by Golden Rule represents a severe threat to representative democratic government.

I urge this subcommittee to consider appropriate measures to ensure that the pursuit of private interests does not threaten or undermine the public good.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you might have.

3/10/94....5548
3/22/94....5689s
05/05/94.....6350h

CHAPTER 294
SENATE BILL - FINAL VERSION

4058B
94-2656
08/09

SB 711

STATE OF NEW HAMPSHIRE

In the year of Our Lord
One Thousand Nine Hundred and Ninety-Four

AN ACT

relative to small employer and individual insurance.

Be it Enacted by the Senate and House of
Representatives in General Court convened:

294:1 Small Employer and Individual Insurance. RSA 420-G is repealed and reenacted to read as follows:

CHAPTER 420-G

SMALL EMPLOYER AND INDIVIDUAL INSURANCE

420-G:1 Purpose. The purpose of this chapter is to make fundamental changes in the way health insurance or health benefits plans are sold and rated by carriers, including health maintenance organizations, to both individuals and small employers in New Hampshire and to achieve the following goals:

I. To facilitate equal access to health insurance and health benefits plans by all New Hampshire residents who wish to obtain it directly or as members of small groups.

II. To promote competition among carriers, insurers and health maintenance organizations on the basis of efficient claims handling, ability to manage heeith care services, consumer satisfaction, and low administrative costs; and to prohibit underwriting and rating practices which allow some insurers to exclude higher risk applicants from coverage and cause unaffordable premium rates to those unable to meet selection standards. Carriers will be expected to manage the risk of individuals or groups having above average experience.

420-G:2 Definitions.

I. "Carrier" means any person, entity, nonprofit corporation or company providing health insurance or the administration of health benefits plans in this state. For the purposes of this chapter, carrier includes a licensed insurance company, a prepaid hospital or medical service plan, a health maintenance organization or any other entity, as listed in

RSA 420-G:9, which provides an individual, employee or small employer with a health insurance plan, health benefits plan or health insurance type plan.

II. "Community rating" means a rating methodology which produces the same premium for every person covered by a policy, certificate, contract form or other evidence of coverage.

III. "Commissioner" means the insurance commissioner.

IV. "Department" means the insurance department.

V. "Health insurance plan" or "health benefits plan" or "plan" means any arrangement with an entity which adjudicates and pays medical claims on behalf of an individual, an employee or dependents. This type of arrangement is evidenced by a hospital or medical policy or certificate, hospital or medical service plan contract, or health maintenance organization group or individual subscriber contract or other evidence of coverage. Health insurance plan does not include accident-only, credit, dental or disability income insurance; coverage issued as a supplement to liability insurance; medicare supplement insurance; workers' compensation or similar insurance; or automobile medical-payment insurance.

VI. "Individual" means a person and that person's dependants who are not eligible for health insurance plans or health benefit plans through employment.

VII. "Individual health insurance policy" means an insurance policy issued by a carrier under title XXXVII of the Revised Statutes Annotated, issued directly to an individual and not on a group or group remittance basis. This chapter does not affect policies covering any one of the following: long term care benefits, nursing home benefits, home care benefits, dental or vision care services, hospital or surgical indemnity benefits with specific dollar amounts, accident only indemnity benefits, accidental death and dismemberment benefits, prescription drug benefits, or disability income benefits, specified disease benefits, or short-term, individual, nonrenewable medical, hospital or major medical policies. For the purposes of this chapter, franchise insurance as defined in RSA 415:19 shall be considered individual health insurance.

VIII. "Open enrollment" means an annual period of at least 60 days prior to the group's anniversary when employees of a small employer shall have the opportunity to enroll in the small employer's plan or change their membership status within that plan. Coverage shall become effective on the group's anniversary date, subject to a 30-day notification to the carrier.

IX. "Qualified association trust or other entity" means an association established trust or other entity in existence on January 1, 1995 and providing health benefit plans covering at least 1,000 employees and /or the dependents of association members, which association:

(a) Was established and maintained for purposes other than the provision of health insurance plans;

(b) Was in existence for at least 10 years prior to January 1, 1995; and

(c) Conducts regular meetings designed to further the interests of its members.

X. "Small employer" means a business or organization which employs one and up to 100 employees, including owners and self-employed persons. A small employer is subject to this chapter whether or not it becomes a part of an association, multi-employer plan, trust or any other entity as cited in RSA 420-G:9 provided it meets this definition. Small employer does not include an employer participating in a pooled risk management program meeting the standards of RSA 5-B or an employer providing benefits through a qualified association trust or other entity as defined in RSA 420-G:2, IX.

XI. "Small employer carrier" means any carrier which offers coverage for a health insurance plan or a health benefits plan for employees, dependents, or both of a small employer.

420-G:3 Health Insurance Plans or Health Benefits Plans Subject to this Chapter.

I. Except as provided in paragraph II, the provisions of this chapter shall apply to any health insurance plan or health benefits plan which provides coverage to small employers employing one and up to 100 employees.

II. The provisions of this chapter shall apply to individual health insurance policies.

III. Notwithstanding any law to the contrary, the provisions of this chapter shall prevail with respect to the subject matter within this chapter.

420-G:4 Practices Relating to Premium Rates and Coverage.

I. Premium rates for health insurance plans or health benefits plans subject to this chapter shall be subject to the following provisions:

(a) All premiums charged to either individuals or small employers shall be solely based on a community rating basis and shall be guaranteed for at least 6 months.

(1) Community rating shall be set by each carrier as the single average premium computed for each month or quarter for each membership type (including single, 2 person, and family) with no modification for gender, geographical location, occupation, health status, individual and/or group claims experience or duration of coverage.

(2) Carriers may modify such average premium for age only in accordance with the following limitations:

(A) During the first calendar year that this chapter is in effect the maximum premium differential for age as determined by ratio shall be 4 to 1;

(B) During the second calendar year and all subsequent years that this chapter is in effect such maximum premium differential shall be 3 to 1.

(3) Carriers modifying such average premium for age may do so only by using the following age brackets.

0-24

25-34

35-44

45-54

55-64

65+

(4) Upon the renewal of an individual or small group policy a carrier is prohibited from increasing the premium rate by more than 25 percent of the rate which applied in the preceeding year. Such rate increase limitation shall not include any premium rate increase which is based on a carriers annual cost and utilization trends; changes in the number of covered members in the group; or changes in group composition due to members moving to a different age bracket. This subparagraph shall expire on January 1, 2000.

(5) The same rating methodology shall apply to individuals or new groups and to individuals renewing and groups renewing at each annual renewal date or anniversary date. There shall be no adjustments in the form of new group discounts, rebates, anticipated refunds, experience, or tier or durational factors or any other factor which affects an individual's or small employer's rate. Rating methodology shall not be construed to include carrier incentives to individual subscribers or members to participate in wellness and fitness programs provided such incentives are approved by the insurance department.

(6) The only other modification to be allowed in community rating will be that component of the administrative fees which reflects the cost of doing business with different group sizes. The commissioner shall not approve any filing if such filing is excessive, inadequate or contrary to the intent of this chapter.

(b) Medical underwriting, the use of individual or small employer group health statements or screenings or the use of prior individual or group claims history to establish or modify premium rates, is prohibited.

(1) Carriers shall not make any adjustments to the community rate due to any past, current or anticipated medical condition.

(2) Carriers shall not make any inquiry about applicant's avocations, hobbies or other activities.

(3) Carriers shall not require attending physician statements, questionnaires or any investigations or reviews regarding health status, health history or family health status.

(4) Carriers shall not knowingly provide coverage to groups where medical underwriting has been performed by the employer or anyone acting on the group's behalf.

(5) Carriers shall not offer riders or endorsements which provide for medical underwriting or offer incentives to individuals or small employers to provide medical information.

(6) Carriers shall not offer riders or endorsements to exclude

certain illnesses or health conditions in order to avoid the purpose of this chapter.

(c) All rates, either for individuals or new small employer groups or for the renewal of existing individuals or small employer groups, shall be provided on a guaranteed acceptance and renewability basis.

(1) Carriers shall actively market, accept and renew all individuals or small employers for all of the benefits plans they sell in the individual or small employer market.

(2) Carriers shall not deny coverage to any person nor any eligible dependent, except in accordance with the provisions of this chapter.

(3) High risk pools are not allowed.

(4) A health insurance plan or health benefits plan subject to this chapter shall be renewable to all individuals or employees and dependents at the option of the small employer, except for the following reasons:

(A) Nonpayment of required premiums.

(B) Fraud or misrepresentation of the individual or small employer, or with respect to coverage of an employee, fraud or misrepresentation by the employee or dependent or such individual or employee's representative.

(C) Noncompliance with plan provisions.

(D) The number of employees covered under the plan is less than the number or percentage of eligible employees required by percentage requirements under the plan.

(E) The small employer is no longer actively engaged in the business in which it was engaged on the effective date of the plan.

(F) The small employer medically underwrites or otherwise violates a provision of this chapter.

II. Individual and small employer health insurance plan or health benefits plan coverage may include waiting periods for pre-existing conditions, but the provisions shall be at least as favorable to covered persons as those set forth in this section.

(a)(1) Except for federally-qualified health maintenance organizations, no waiting period provision shall exclude coverage for a preexisting condition period in excess of a period of 3 consecutive months ending while the individual's health insurance plan is in force and during which the individual incurred no medical care treatment expenses in connection with the preexisting condition, nor for a preexisting condition period in excess of 9 months following the effective date of coverage for the covered person and may apply only to conditions manifesting themselves in symptoms or conditions for which medical advice was received or recommended or which caused or would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment and/or was recommended or received during the 3 months immediately preceding the effective date of coverage.

(2) For federally-qualified health maintenance organizations, no preexisting condition provision shall impose a copayment for a preexisting condition that exceeds 50 percent of the cost of providing services for that condition. Copayments on preexisting conditions may be charged for 12 months following the effective date of coverage for the covered person and may apply only to conditions manifesting themselves in symptoms or conditions for which medical advice was received or recommended or which caused or would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment and/or was recommended or received during the 3 months immediately preceding the effective date of coverage.

(b) In applying a preexisting condition provision to an eligible person, the carrier shall credit the time the person was covered under previous health insurance or health benefits plans, whether insured or self-insured.

(1) If the individual, employee, or dependent did not have a health insurance plan or health benefits plan during a period of unemployment prior to the effective date of new coverage, the lack of coverage during the period of unemployment shall be disregarded and, when applying the continuous coverage requirement of this subparagraph to an eligible person, coverage shall be considered to have been continuous from the date of the termination of any health benefit plan insuring the individual immediately prior to the period of unemployment to the effective date of the new coverage. The period of unemployment shall also be credited toward the time needed to satisfy any waiting period provision of the new coverage.

(2) An employee who declines a small employer's plan during the initial offering or subsequent open enrollment periods shall be a late enrollee and shall not be allowed on the plan until the next open enrollment period. However, an eligible employee or dependent shall not be considered a late enrollee if the individual:

(A) Was covered under a public or private health insurance or other health benefit arrangement at the time the individual was able to enroll; and

(B) Has lost coverage under a public or private health insurance or other health benefit arrangement as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse, or divorce; and

(C) Requests enrollment within 30 days after termination of coverage provided under a public or private health insurance or other health benefit arrangement; or

(D) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(E) A court has ordered coverage to be provided for an ex-spouse or a minor child under a covered employee's health benefit plan

and request for enrollment is made within 30 days after issuance of such court order.

III. A small employer carrier may not require more than 75 percent of the employees eligible for benefits in a small employer group to participate in the carrier's health insurance or health benefits plan, except as noted below.

(a) For the purpose of calculating whether or not a small employer group meets the minimum enrollment requirements, the number of eligible employees shall be counted as the total number of full-time employees and part-time employees who are eligible for benefits. Any full-time or part-time employee who is covered as a dependent on another health insurance or health benefits plan shall be excluded from the count.

(b) A carrier, when calculating the participation percentage, shall not consider employees who have coverage under another health insurance plan or health benefits plan sponsored by the same employer.

(c) The minimum participation requirements shall be calculated on an employer-by-employer basis if the small employer is part of an association, trust or other similar arrangement.

(d) In performing the computation to determine the actual enrollment required for qualification as a small employer plan, the small employer carrier shall calculate 75 percent of the actual number of eligible employees, defined in RSA 420-G:4, III(a) and (b), and round any factional number to the higher integer.

IV. There shall be an annual open enrollment period of 60 days prior to a group's anniversary when employees or dependents can apply to the small employer for coverage upon the small employer's anniversary date.

(a) A carrier shall not refuse any eligible employees or dependents applying for coverage during the open enrollment period.

(b) A carrier shall not use medical underwriting questionnaires or health statements for any employees or dependents eligible for enrollment.

(c) Employees or dependents coming on at the time of an open enrollment period shall have the same premiums as the rest of the small employer group shall have upon the new or renewal effective date.

V. All carriers shall electronically provide claims data to the division of public health services, department of health and human services, or its agent.

VI. All carriers shall accept electronic claims submitted in health care financing administration (HCFA) format for UB-92 or HCFA-1500 records, or as amended by HCFA.

420-G:5 Qualified Association Trust or Other Entity. A qualified association trust or other entity as defined in RSA 420-G:2, IX shall:

I. Use the community rating methodology outlined in RSA 420-G:4, I(a)(1)-(6) for all small employer members with 100 or fewer employees based upon the associations group experience;

II. Offer all eligible members as defined under the applicable trust or other documents, coverage and rate on a guarenteed issue and renewability basis;

III. Comply with the prohibitions concerning medical underwriting contained in RSA 420-G:4, I(b)(1)-(6), and

IV. Comply with the preexisting conditions provisions of RSA 420-G:4, II.

420-G:6 Disclosure of Rating Practices and Renewability Provisions. Each carrier shall make reasonable disclosure in solicitation and sales materials provided to individuals and small employers of the following:

I. The methodology by which premium rates for an individual or specific small employer are established. Each carrier shall state that rates and practices are in full compliance with this chapter.

II. The provisions concerning the carrier's right to change premium rates and the factors which affect changes in premium rates.

III. The provisions relating to renewability of coverage.

420-G:7 Maintenance of Records.

I. Each carrier shall maintain at its principal place of business a complete and detailed description of its rating practices and renewal underwriting practices, including information and documentation which demonstrate that its rating methods and practices are based upon commonly accepted acturial assumptions and are in accordance with sound actuarial principles.

II. Each carrier shall file each March 1, with the commissioner, an actuarial certification stating that the carrier is in compliance with this section and that the rating methods of the carrier are actuarially sound.

III. A carrier shall make the information and documentation described in paragraph I available to the commissioner upon request.

420-G:8 Filing of Rates. No policy or contract of insurance or any certificate under such policy or contract or other evidence of coverage shall be issued under this chapter until the premium rates have been filed and approved by the commissioner. The commissioner shall approve or disapprove such rates within 30 days of receipt. The commissioner may disapprove rate filings if he finds such rates to be excessive, inadequate or contrary to the intent of this chapter.

420-G:9 Rulemaking. The commissioner shall adopt rules, under RSA 541-A, necessary to the proper administration of this chapter.

420-G:10 Applicability; Carriers.

I. This chapter shall apply to any entity licensed, controlled or regulated by RSA 415, RSA 415-E, RSA 419, RSA 420, RSA 420-A, RSA 420-B or RSA 420-C which offers or provides individual or small employer health

insurance plans or health benefits plans for delivery in this state. This chapter shall also apply to any multi-employer plan, trust, association, claims administrator, claims paying agent or any other entity whether fully insured, partially insured, or self-funded which offers or provides individual or small employer health insurance plans or health benefits plans for delivery in this state. This chapter shall not apply to pooled risk management programs which meet the standards established by RSA 5-B.

II. Notwithstanding any other provision of this chapter, any multiple employer welfare arrangement which meets the requirements of RSA 415-E:2, III shall be exempt from the provisions of this chapter until January 1, 1998.

420-G:11 Severability. If any provision of this chapter or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the chapter which can be given effect without the invalid provisions or applications, and to this end the provisions of this chapter are severable.

420-G:12 Penalties. Any carrier who proposes, advertises, solicits, issues or delivers to any person or entity in this state any form which does not comply with this chapter or who shall in any way violate this chapter may:

I. Be prohibited from marketing, selling or otherwise administering to the individual or small employer market if the commissioner finds a carrier to be in violation of RSA 420-G.

II. Be subject to an administrative fine not to exceed $2,500 for each violation. Repeated violations of the same chapter shall constitute separate fineable offenses.

III. Have its certificate of authority indefinitely suspended or revoked at the discretion of the commissioner.

294:2 Commissioner's Report. The insurance commissioner shall issue a report to the governor, the senate president and the speaker of the house regarding the implementation of the community rating system no later than January 1, 1998. The report shall include the effect of community rating on premiums, the availability of insurance and the uninsured population in the state.

294:3 Effective Date. This act shall take effect January 1, 1995.

Approved: June 6, 1994
Effective: January 1, 1995

February 17, 1994
Room 203, Legislative Office Building
8:42 am

The Senate Committee on Insurance held a hearing on the following:

SB 711 An act relative to small employer and individual insurance.

Committee members present:

Senator Joseph Delahunty, Chairman
Senator Beverly Hollingworth, Vice Chairman
Senator C. Jeanne Shaheen
Senator Kenneth MacDonald
Senator Clesson Blaisdell

Senator Joseph Delahunty opened the hearing by calling upon one of the sponsors of the bill.

Senator Leo W. Fraser, Jr., D. 4: Good morning. Senator Shaheen is going to discuss the pertinent parts of SB 711. I am here as a co-sponsor, something I am very proud to do.

You will find a great deal of support for what I would call leveling the playing field. It's good legislation. There might be some minor adjustments that would have to be made by the Committee to address some of the concerns you are going to hear. (See Testimony A)

Mr. Chairman, you have a long history of being able to get the parties together. I think this is going to be a challenge to you on this bill. But if anyone can get a good bill out of this Committee I'm sure you will.

Consistent with what I am suggesting as minor adjustments, I have an amendment. It was never contemplated, at least in my view, that the New Hampshire Municipal Health Trust would be included in SB 711 and I'm not sure that they are.

But the Trust has asked me to introduce an amendment so that if you look at the bill, all that it says is that SB 711 does not apply to any political subdivisions created by RSA 5B. 5B Is enabling legislation that was created a number of years ago. There are 296 members of the New Hampshire Municipal Health Trust.

Kent Hotham, who is the Manager of that trust, will speak in greater detail about their position on this bill. All I am asking is that the Committee adopt the amendment #5240B which specifically excludes from SB 711 the New Hampshire Municipal Health Trust.

I am very happy to be on the bill to assist Senator Shaheen. I think it is good legislation.

Senator C. Jeanne Shaheen, D. 21: (Passes out Amendment, Testimony B-1)

SB 711, I believe, is one of the pieces of health care reform that we need to enact. It would change the way insurance companies market and price health insurance to individuals and small businesses with twenty or fewer employees.

It makes three fundamental changes in the way insurance carriers would provide coverage. First of all it would require community rating. Each carrier would set their rates with no modifications for age, gender, geographic location, health status, individual or group experience or duration of coverage.

Secondly, it would prohibit carriers from denying coverage because someone has a preexisting condition.

Third, it would require guaranteed issues so that carriers would be required to actively market, accept and renew all individuals or small employers for all benefit plans.

You have in front of you an amendment which basically addresses technical changes that the Insurance Department has with the original draft of the bill that you have. I can address those if you like but my preference would be to make the Insurance Department's remarks available to members of the Committee because as I said most of those are technical changes.

It has been suggested that this is a bill that is a "Blue Cross bail out bill" and it's been introduced simply to benefit Blue Cross. That certainly is not the case. They have been involved with us in the drafting of the bill but this is a bill that comes as a result of work that has been done by a coalition of groups interested in health care reform who've been meeting for over a year.

I would hope that we can make decisions about insurance reform based on what would benefit our ability to provide affordable health insurance to the greatest number of people in the state. It is my hope that decisions about the kind of insurance that is provided should not be driven by a small number of commercial carriers who write little or no insurance in the state.

The changes that are introduced in SB 711 are coming. All of the national health care reform plans include these three provisions. Thirty-seven states have already enacted pre-existing condition limitations. The neighboring states of Vermont, Maine and Connecticut have already adopted some form of community rating. I believe it is time for us now to fashion insurance reform in a way that we think will work in New Hampshire.

Finally, I think all of the supporters of this bill are concerned about what the potential impact on rates will be when it gets enacted. We certainly are interested in working with the Insurance Department, Commissioner Bird of Health and Human Services, and with all of those businesses and companies who are concerned about that aspect. I view this as an on-going process and we are interested in continuing to work with everybody and listening to what people have to say.

(Passes out Testimony B-2 and B-3)

Harry Bird, MD - Commissioner, Department of Health and Human Services: I would like to speak today in support of SB 711. It is known to all of you that when the Governor's proposals for health care improvement were released in 1993, part of those spoke to our belief that insurance reform was a necessary part and in particular issues relating to community rating and to the problems that pre-existing conditions have caused for many of us.

We hope that this bill will be the vehicle that will lead to an enactment before the session is over.

I would like to raise two concerns. These issues of process and phasing are not disagreements over the concept of the bill at all. I speak particularly to the issue of pure community rating and the risk that we believe that engenders to a state like New Hampshire when the system of insurance is voluntary and we believe will continue to be for some time.

As you know right now there are differences in rates and premiums between people and it is often based on age. They are varied all over the place. Our concern is the unknown risk of too rapid and too directly compressing all of these rates to a single rate without regard to age.

So one of the things that we feel is very important is that you consider incorporating into this the best judgment you can on how we balance moving to community rating which we support and at the same time not disrupting the system.

Our concern is that young people, if faced with large premium increases could in fact decide to walk away from insurance. If we have large numbers of younger people who are paying lower rates at the moment who are faced with dramatic increases too rapidly we believe this will be harmful to the very community rating we are trying to create.

We think that this needs then two issues considered. One being that there will probably need to be some permanent difference relating to age in the bill and that how you get there may not be serving New Hampshire best by doing it all by July 1. We ask you to consider some form of phase-in for what we are talking about over some defined period of years.

We have another concern which we would like you to address which is an issue that is difficult - personal responsibility and lifestyle in terms of how insurance premiums are affected. We know that if you were to just allow everybody to claim that because I am healthy and don't have any medical problems that I should get a special rate on my insurance - if you leave that open ended I think you end up destroying community rating.

On the other hand it is our experience the public is used to an experience rating concept. I believe there is reason to try to address that concern with somebody who is trying to improve the quality of their life by assuming personal responsibility for their health and that should be acknowledged somehow in what you are trying to create in SB 711.

We see the risk in that and we believe that whatever happens in that regard needs to be very carefully done and should be very clearly spelled out - perhaps some modest premium discount actually identified and not left to be open ended.

One example would be to turn to the state. We maintain on an ongoing basis some ten or twelve health risk assessments that we cover the whole state with in terms of blood pressure checks, pap smears, mammograms, non smoking and perhaps some use of those lifestyle improvement issues could be used to qualify people for some modest acknowledgment of good lifestyle. We do ask you to consider that as you consider this bill.

We also saw the changes submitted by the Insurance Company and the we do support them.

On section 5 of the bill there has been some question as to whether our Department is prepared to receive data and whether we were ready to use it and that is not an issue and does not require any change. We urge you to consider the changes that have been recommended and we look forward to seeing the bill in a form that we can support enthusiastically.

Representative Clifton Below - Graf, 13: I support this bill. It will address discrimination in health insurance based on genetic characteristics. This is an emerging problem because of the technologies growing.

Just a month ago Time magazine had a special report on the topic and illustrated the variety of genetic diseases that can now be tested for early in life and in fact somebody can be denied insurance.

Robert Greenleaf - Board of Directors, N.H. Lodging and Restaurant Association: We in concept support SB 711. It is important to us and the hospitality industry as we employ over 40,000 workers. We applaud recent legislative efforts, especially HB 341 which mandates the insurance market place to be more accessible and user friendly to the small employer. We believe that SB 711 is another step in securing the ability of small employers to access and retain stable and predictable insurance rates. We fully support the provisions of SB 711.

More importantly, SB 711 would improve the predictability certainly of health care insurance costs for small employers at times of renewal.

As currently written, however, we cannot fully endorse SB 711. Generally speaking the Hospitality employer employs younger, healthier workers and as such we are very concerned with the provisions regarding community rating. Evidence indicates that the rates for younger, healthier individuals would increase to offset the cost associated with other groups. If the Committee moves toward accepting community rating as a solution we urge you to seriously consider a phased-in approach.

In addition, adjustments in community rating for age, gender and possibly geography should possibly be carefully examined as appropriate. Also Commissioner Bird mentioned about incentives for employers and employee groups to promote healthy lifestyles and we think that is also appropriate.

Representative Robert Foster - Carr. 10: I am one of the sponsors and I support what Dr. Bird has said.

Don Pfundstein - N.H. Bankers' Association: The Bankers' Association not only supports the concepts but the core provisions of SB 711. I agree with Senator Shaheen that no one should call this bill a Blue Cross/Blue Shield bill.

The New Hampshire Bankers' Association established a trust to buy insurance for its members, I believe in 1957. There are approximately 1700 people who are employees or their dependants of basically a small number of banks. We buy all of our products through Blue Cross/Blue Shield. They are all fully insured.

We support the core provisions of SB 711 - community rating, guaranteed issue, guaranteed renewability, prohibition against medical underwriting, reasonable preexisting conditions provisions. These are not new ideas to our trust. We've been using those ideas for some time. Through careful management and the judicious application of those principals to our trust we have allowed our members to enjoy good health insurance that is efficiently operated and efficiently priced.

If we look at SB 711 as a mass-transit system to health insurance to move more people quicker towards what we might call better insurance coverage. Our trust might be viewed as a simply park-and-ride van. The members and employees and dependants drive to the parking lot and get on the van and we rattle down the road to the same destination of Better Insurance Town. In fact we've been driving that van down the road long before that bill was drafted and we follow the same traffic signs.

What we're asking for today is that you not try to create this mass-transit system, crush our van, and send it to the salvage yard. What we are asking for is a restrictive grandfather provision, not an exemption, but a restrictive grandfather provision.

Senator Fraser introduced an amendment that I understand is designed to rely upon the provisions of RSA 5B for the Municipal Association to be exempted from the provisions of this bill and I'm not here today to tell you I don't support that. But I want to use that as a way of defining the distinction between what we are asking for and what the amendment the Municipal Association is seeking.

Our amendment says that yes, we will apply with the community rating methodology in the bill, but we would like to do it for members that have fifty employees or less. We will comply with the numerical underwriting prohibitions of the bill. We will comply with the guaranteed issue and guaranteed renewability provisions and we will comply with those provisions concerning using preexisting conditions in other than a reasonable fashion to guard entry into the trust.

(See Amend, Testimony C)

So we're not asking for an exemption, we're asking for a restrictive grandfather provision and we think it is appropriate. We kind of think we've got a lot of miles left on our van.

Our consulting actuaries have told us that of states that have adopted community rating legislation, none of them that they are aware of crushed the van of an otherwise qualified association trust.

If you look at the issue of how many people you need in the pool to have community rating operate properly should we consider the 40,000 people in the municipal trust or the 1700 people in the bankers' trust? If we look at the comparison between this legislation and that on the federal level, there is a significant distinction.

The Federal legislation started with the core concept of universal coverage. They said we'll make insurance available to everyone using community rating. When you impose those types of differentials in paying from community rating that other people spoke of earlier in terms of the rate increases, I think it's a little bit different distinction than what this bill does itself. That is not to suggest that the Bankers' Association opposed community rating we're only asking that we be able to do it in our own van as opposed to a mass-transit system.

(End of Tape)

.......What it does is it asks you to consider deleting the section in 711 dealing with the minimum participation underwriting guidelines. Currently some companies use a minimum participation requirement of 75%. That concept was developed to deal primarily with the situation of cherry picking.

If you've got 50 employees and an employer viewing it, all the young healthy people are picked off by some company at lower rates, those minimum participation requirements make sense so that a company is not forced to take the more expensive.

However, in community rating over time you would expect that all the rates with the companies would come somewhat more into line with each other so that the differentials are less. You really don't need this minimum participation requirement to any degree that you needed it when cherry picking was the law. If you can demographically rate and pull out the good risks then you should have some minimum participation requirement to protect the carrier of last resort or the people who are in the market.

Senator Beverly A. Hollingworth, D. 23: In fact your amendment would do a lot more than just grandfather. You would have to allow a (inaudible) for all trusts that would be set up such as yours after the fact. Is that not true?

Don Pfundstein: I don't believe that is true.

Senator Beverly A. Hollingworth, D. 23: I don't see that it says......

Don Pfundstein: Roman number 11, an association of established trust ....., section 2, first page.

Senator Beverly A. Hollingworth, D. 23: "In existence", that's what I was looking for.

Committee recesses for five minutes.

Hearing reopened

John Swope - President, Chubb Life America:

(See Testimony D-1)

(See Amendment, Testimony D-2)

Lisa Carroll - Small Business Service Bureau, Inc.:

(Reads Testimony E)

Senator C. Jeanne Shaheen, D. 21: It has been suggested to me that one of the concerns that the associations have is that this will permit individual employers to buy insurance with the same benefits and rates and would eliminate the reason why employers join a corporation.....

(End of Tape)

Lisa Carroll: ......continuing a lot of their abusive practices and the Insurance Department can probably give you a list of complaints from people who are enrolled in these association products. By including exception language you create a loophole in which these associations can come into the state and really undermine the intent of your reform.

That's the biggest problem we have. The carriers, HMOs, the majority of small group associations in Massachusetts all agree that the association exemptions should be deleted from our existing legislation.

It's our large commercial carriers which I will not name that are the ones that are fighting for it because even though they have a small amount of business in state compared to what they have in the rest of the country, they want to continue underwriting and rating it as they have historically.

But we have some real problems down there right now that are compounded by the fact that we don't have the resources in the Insurance Department to go after these groups that for the most part are bogus groups.

Michael Valuk - Greater Nashua Chamber of Commerce:

(See Testimony F)

Senator Beverly A. Hollingworth, D. 23: Doesn't the Nashua C.O.C. offer health care insurance to its employees?

Michael Valuk: Not as a specific part of the Chamber. We have a number of members who offer insurance to our members as an element of Chamber membership. We are not linked in any way to a specific product. We do not endorse any specific product. We endorse all of the products offered by all of our members.

Senator Beverly A. Hollingworth, D. 23: So your employees are not covered by the Chamber? They have to go outside of the workplace?

Michael Valuk: For the employees we are with an HMO.

Senator Beverly A. Hollingworth, D. 23: So you do have health care coverage?

Michael Valuk: Yes.

Dan McLeod - N.H. Automobile Dealers' Association: Our position is to support this bill and to support it with the amendment that Don Pfundstein brought in for the Bankers' Association. I guess you can say we sold them the van and we're riding right along side them with it.

I think what the Committee ought to recognize is that we're not seeking an exemption from this bill. We are not seeking an exemption whatsoever. We actually welcome the key elements of the bill. We are currently, with our association plan, with Blue Cross which is a fully funded plan with approximately 1700 lives in that plan.

The past history of the Association is that our program started in 1948 and I think when you talk about Association health insurance programs, which is what we have had and want to continue to have, we are very service oriented and have always treated all members equally. As a matter of fact last year we started the N.H. Automobile Dealer Association Employee Benefit Trust and this arose out of a desire to be proactive and assist association members in a wellness program. It is somewhat similar to the loss prevention efforts we've made under our workers' compensation trust program.

There has been tremendous enthusiasm by the trustees, association members and by the association staff with this wellness program. We know that it is going to impact members and their employees in future years and we want to make sure we can continue this in future years.

We believe that we have the best insurance coverage and superior service combined with the wellness program . Our amendment supports the community rating aspect, the guaranteed issue aspect. We still believe there should be no medical underwriting.

We support the aspect you have in there with pre-existing conditions. Under our amendment we are not going to opt out. We are not seeking an exemption from this bill. We want to maintain the Association touch with our health insurance program. We believe if you accept our amendment we will continue to do so. If you do not our program is in trouble.

We think we can do a good job with our wellness program in the years to come. I'd like to just say that our amendment does not accept any new association plans - its a plan that has been in existence for ten years. It isn't just an association that is established to provide health benefits. It is an Association program that provides many other benefits to like members. The amendment is restrictive in that regard.

Kent Hotham - New Hampshire Municipal Association Insurance Trust:

(See Testimony G)

We oppose the bill as written but would support the amendment that's been offered to you today.

Zandy Taft - Blue Cross and Blue Shield of New Hampshire:

(See Testimony H)

Tom Clairmont - New Hampshire Hospital Association Committee on Insurance:

(See Testimony I)

Ron Aveni - The Aveni Agency, Milford: I have some concerns on the guaranteed issue aspect that the proposal would provide. My concern is what they call "gaming". The reason that healthy people purchase health insurance is the fear they may lack such insurance if they become sick.

However, if health insurance becomes available, regardless of health status, much of the incentive to pay for insurance while healthy is removed. It would become a rational choice to do without health insurance until the need arises.

Automobile insurance provides a good analogy. If it were possible to purchase auto insurance after an accident occurred, would people be likely to purchase insurance before the accident?

What is insurance? Insurance is a business of risk allocation in which the insured receives payment in exchange for bringing to cover the expense of certain risks. The cost and scope of coverage is determined by morbidity/mortality statistical analysis. To the degree that insurers are prevented from basing their contracts on such actuarial values, other policy holders will be forced to hold the additional costs. Thus in order to provide coverage for a person with AIDs, a person without AIDs must pay a higher premium.

Moreover, the additional costs are highly aggressive forcing the highest margin of those costs on those least able to afford the increase. For example if community rating causes the premium for a family policy to increase by $1000.00 per year, that's a 5% surcharge for a family earning only $20,000.00 a year but only a 1% surcharge for a family earning $100,000.00 a year.

We should also realize that community rating relieves individuals of the responsibility of unhealthy lifestyles. There is no question that individuals who smoke, drink, use drugs, practice unsafe sex, have poor diets and fail to exercise have far higher health costs than individuals with healthy lifestyles.

In fact the ten top causes of death in the U.S. are all lifestyle related. By spreading the cost over the entire population, community rating and guaranteed issue are socialize the cost in the truer sense of the word. This is only one aspect that I have concerns about. I don't have answers. This is a big problem for our whole society.

Julie Nienaber - Public Policy Analyst, Golden Rule Insurance Co.: I'd like to start out by saying that Golden Rule does oppose the use of genetic testing in underwriting and would also support portability of insurance which would allow a planholder who has been in the system for a year or more to keep that insurance and carry it with them however we do have grave concerns about the guaranteed issue as it is written in this bill.

(See Testimony J)

Senator C. Jeanne Shaheen, D. 21: You gave us an article. There is a memo here from the Insurance Department of New Hampshire which is based on a conversation with the Insurance Department in New York where they point out that 60% of the markets received an increase or a decrease of less than 20% and that the premium had stabilized and that no companies had requested rate increases during the first year after originally filing rates.

Julie Nienaber: Thank you for sharing that.

Victoria Craig - Council For Affordable Health Insurance:

(See Testimony K)

Kristen Kelly - Matthew Thornton Health Plan:

(See Testimony L)

Karen Hicks - New Hampshire Citizen Action:

(See Testimony M)

Janet Schaffer - N.H. AFL-CIO:

(See Testimony N)

Mary Ann Barton - N.H. Women's Lobby, N.H. Breast Cancer Coalition, N.H. School Nurses' Association and the N.H. Chapter of N.O.W.:

(See Testimony O)

Paula Rogers - Health Insurance Association of America:

(Due to faulty tape initial comments were not recorded audibly enough to transcribe.)

(End of Tape)

(From Secretary's notes: They disagree with the concept of pure community rating and the Committee should reconsider some of the components of 341.)

John Crosier - BIA:

(See Testimony P)

Robert Sculley - President, N.H. Motor Transport Association:

(See Testimony Q)

Keith Vaskelionis - Law Enterprises: (They are in the motor carrier business. Speaks in opposition to the bill as written)

Senator C. Jeanne Shaheen, D. 21: What happens to those who can't get coverage?

Keith Veskelionis: There are three cases where coverage has been denied. One got insurance in Portland, one with the Teamsters and one was with the Blues I think.

David Dustin - N.H. Motor Transport: (Spoke in Opposition to the bill as written saying that 17% of their payroll goes to insurance costs.)

Mark Wilson - Gale Drayline Co., Inc.: (Speaks in opposition to bill as written)

Robert Yager, M.D. - N.H. Health Care Coalition:

(See Testimony R)

Elizabeth K. R. Vonck - N.H. Multiple Sclerosis Society:

(See Testimony S)

Sara Dustin - Parents for Justice: (Speaks in support of the legislation)

Peter Wells - Healthsource: (Speaks in support of the Legislation)

Representative Elizabeth Crory - Graf. 1: (Does not wish to speak but supports the legislation)

Hearing adjourned
11:26 am

Respectfully submitted by Terri Pennock

February 16, 1994
5240B
08

Amendment to SB 711

Amend RSA 420-G:9 as inserted by section 1 of the bill by replacing it with the following:

420-G:9 Applicability; Carriers. This chapter shall apply to any entity licensed, controlled or regulated by RSA 415, RSA 415-E, RSA 419, RSA 420, RSA 420-A, RSA 420-B or RSA 420-C which offers or provides individual or small employer health insurance plans or health benefits plans for delivery in this state. This chapter shall also apply to any multi-employer plan, trust, association, claims administrator, claims paying agent or any other entity whether fully insured, partially insured, or self-funded which offers or provides individual or small employer health insurance plans or health benefits plans for delivery in this state except pooled risk management programs organized under RSA 5-B.

Amend RSA 420-G:2, VII as inserted by section 1 of the bill by replacing it with the following:

VII. "Individual health insurance policy" means an insurance policy issued by a carrier under title XXXVII of the Revised Statutes Annotated, issued directly to an individual and not on a group or group remittance basis. This chapter does not affect policies covering any one of the following: long term care benefits, nursing home benefits, home care benefits, dental or vision care services, hospital or surgical indemnity benefits with specific dollar amounts, accident only indemnity benefits, accidental death and dismemberment benefits, prescription drug benefits, or disability income benefits, specified disease benefits, or short-term, nonrenewable medical, hospital or short-term, individual major medical policies. For the purposes of this chapter, franchise insurance as defined in RSA 415:19 shall be considered individual health insurance.

Amend RSA 420-G:2, IX as inserted by section 1 of the bill by replacing it with the following:

IX. "Small employer" means a business or organization which employs one and up to and including 100 employees who shall be considered eligible for the benefits of the employer's health insurance plan by the employer. For the purposes of this chapter owners and self-employed persons shall be considered as employees.. A small employer is subject to this chapter whether or not it becomes a part of an association, multi-employer plan, trust or any other entity as cited in RSA 420-G:9 provided it meets this definition.

Amend the introductory paragraph of RSA 420-G:4, I(a) as inserted by section 1 of the bill by replacing it with the following:

(a) All premiums charged to either individuals or small employers shall be solely based on a community rating basis and shall be guaranteed for at least 6 months. Insurers filing revised rates for individual or group health insurance policies shall include in each rate filing premium rates that apply to all outstanding policy forms which provide like or similar benefits. The premium rates for any individual or group health insurance policy form shall be based on a community rating basis where the community includes all other individual or group health insurance policy forms providing like or similar benefits. The initial rates for a new individual or group health insurance policy form shall be the current community rates applicable to all existing policy forms that provide like or similar benefits. Premium rates for individual or group health insurance policy forms shall be permitted to include appropriate adjustments for differences in benefit levels.

Amend RSA 420-G:4, I(a)(2) as inserted by section 1 of the bill by replacing it with the following:

(2) Premium rates based on a community rating methodology shall apply to new individual health insurance policies and new group insurance policies as of the date of issue, or the effective date, if earlier, beginning on or after January 1, 1995. Premium rates based on a community rating methodology shall apply upon the renewal of any individual health insurance policy or group insurance policy, beginning with the first anniversary date or annual renewal date falling on or after January 1, 1995.

Amend RSA 420-G:4, II(a) as inserted by section 1 of the bill by replacing it with the following:

(a) No waiting period provision shall exclude coverage for a preexisting condition period in excess of a period of 3 consecutive months ending while the individual's health insurance plan is in force and during which the individual incurred no medical care treatment expenses in connection with the preexisting condition, nor for a preexisting condition period in excess of 9 months following the effective date of coverage for the covered person and may apply only to conditions manifesting themselves in symptoms or conditions for which medical advice was received or recommended or which caused or would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment and/or was recommended or received during the 3 months immediately preceding the effective date of coverage.

Amend RSA 420-G:4, II(b)(1) and (2) as inserted by section 1 of the bill by replacing it with the following:

(1) If the individual, employee, or dependent did not have a health insurance plan or health benefits plan during a period of unemployment prior to the effective date of new coverage, the lack of coverage during the period of unemployment shall be disregarded and, when applying the continuous coverage requirement of this subparagraph to an eligible person, coverage shall be considered to have been continuous from the date of the termination of any health benefit plan insuring the individual immediately prior to the period of unemployment to the effective date of the new coverage. The period of unemployment shall also be credited toward the time needed to satisfy any waiting period provision of the new coverage.

(2) An employee who declines a small employer's plan during the initial offering or subsequent open enrollment periods shall be a late enrollee and shall not be allowed on the plan until the next open enrollment period. However, an eligible employee or dependent shall not be considered a late enrollee if the individual:

(A) Was covered under a public or private health insurance or other health benefit arrangement at the time the individual was able to enroll; and

(B) Has lost coverage under a public or private health insurance or other health benefit arrangement as a result of termination of employment or eligibility, the termination of the other plan's coverage, death of a spouse, or divorce; and

(C) Requests enrollment within 30 days after termination of coverage provided under a public or private health insurance or other health benefit arrangement; or

(D) The individual is employed by an employer which offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(E) A court has ordered coverage to be provided for an ex-spouse or a minor child under a covered employee's health benefit plan and request for enrollment is made within 30 days after issuance of such court order.

Amend RSA 420-G:5, I as inserted by section 1 of the bill by replacing it with the following:

I. The methodology by which premium rates for an individual or specific small employer are established. Each carrier shall state that rates and practices are in full compliance with this chapter.

Golden Rule®

TO: Chairman and Committee Members
FROM: Julia Nienaber, Public Policy Analyst
RE: New Hampshire SB 711 February 17, 1994

Chairman and Members of the Committee:

Thank you for the opportunity to provide information on SB 711 which would require changes in the New Hampshire insurance law. My name is Julia Nienaber and I represent Golden Rule Insurance, the nation's largest individual health insurance company. Golden Rule offers health and life insurance plans to New Hampshire residents. I am here representing my company and the 5,343 New Hampshire planholders we insure.

The stated intent of this bill is to facilitate equal access to insurance for all New Hampshire residents. However, experience in other states which have enacted similar reforms show the opposite is likely to happen. By forcing younger insureds to pay higher premiums through community rating, insurance is made inaccessible because it is unaffordable. The premium rates are also driven higher when guaranteed issue is enacted because the incentive to buy insurance is removed. If a person can buy coverage after they become ill, as they can under guaranteed issue, persons are actually encouraged to drop insurance knowing they can obtain coverage after they are sick. As healthy people leave the system, costs are driven higher.

Of the Golden Rule insureds who purchased insurance in the last two years and who reported family income, almost 60% of our insureds have household incomes under $25,000 a year (Chart 2). It is probably optimistic to believe they can afford even a 5% increase on annual premiums. Additionally, as demonstrated on Chart 5, individuals earn less in their 20's and 30's. However, under community rating, it is this age group which is hit hardest. As shown on Chart 1, we estimate a 22-year-old Golden Rule insured could see an increase of nearly 250% under the proposals in SB711. The largest decrease in premiums under SB 711 will be for a 62-year-old. As Chart 4 shows, you are asking a person at his or her lowest earning point to pay a much larger percentage of income for health insurance.

These numbers are not just estimations. The state of New York

olden Rule Insurance Company

Home Office
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439
Telephone (618) 943-8000

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

enacted similar reforms effective April 1, 1993. As the attached New York Daily Times article shows, rates for a 30-year-old man increased 170%. Groups were being forced to drop coverage. Finally, New York senators who voted for the bill testified at a recent National Conference of Insurance Legislators meeting that initial Department of Health numbers indicted there were millions more uninsured persons after the law was enacted.

The attached Burlington Free Press article shows that residents in states where these reforms are in place consider these laws to simply be additional taxes. The Vermont resident in the article explains he became uninsured when his employer went out of business. He was able to obtain insurance, however due to a Vermont law similar to provisions in SB 711, he believes his insurance will soon be inaccessible because it will be unaffordable.

The Academy of Actuaries says only 1% of the population in the United States is medically uninsurable.

I would ask you to consider three questions before voting on Senate Bill 711.

1) IS IT FAIR? Is it fair to make a young person who is at the low end of his or her lifetime earning cycle and who represents a lower health risk to shoulder significantly higher premiums? Is it fair he or she should be forced to pay over 8% of his or her income for health insurance while a 60-year-old who is likely incurring significantly higher health costs pays just over 4% of his or her income for insurance?

2) IS IT EQUITABLE? Is it equitable to make a 20-year-old pay an equal premium as a 60-year-old? Equal premiums are not equitable when a 60-year-old is likely incurring much higher costs than the 20-year-old.

3) Finally, is this a reform that will help or hurt the overall health care system? If you agree that you want more people to be insured, vote "no" on SB 711. This bill encourages people to drop insurance by allowing people to buy insurance after they become ill. This bill drives young people out of the insurance market by driving costs up.

There are a number of reforms New Hampshire could consider and which we do endorse. Over 25 states have successfully developed state high risk pools to provide coverage for persons who are medically uninsurable. A pool can be established that is funded by equitable means and which does not encourage people to wait to buy insurance.

The New Hampshire legislature could also pass resolutions to the United States Congress asking for tax equity and the establishment of Medical Care Savings Accounts. In general, tax equity would give an uninsured waitress the same tax write-off for buying her own insurance that a large corporation receives. Medical Savings Accounts would bring consumers more directly in to the purchase of health care thereby driving costs down.

Golden Rule is happy to provide more information on these reforms and many others which we endorse and encourage.
I thank you for the opportunity to speak and for your patience.

CHART 1

NEW HAMPSHIRE PREMIUMS
Annual Age-Rated Adult
$500 Deductible

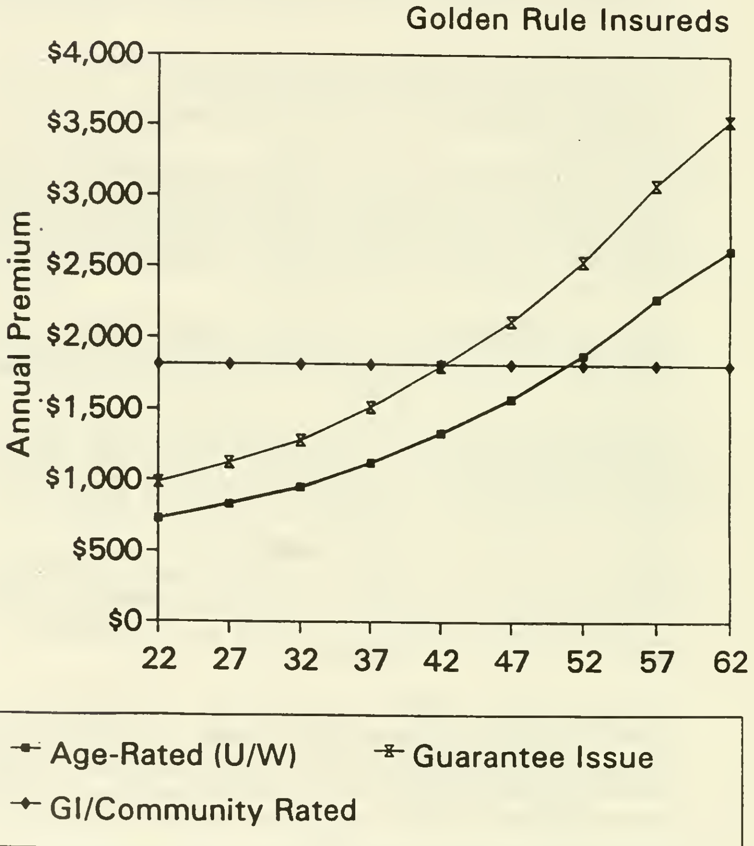


Illustration Zip 03801

CHART 2

NEW HAMPSHIRE POLICYHOLDER

INCOME DISTRIBUTION

	----All Deductibles----			
	New Hampshire		Nationwide	
Income	Count	Percent	Count	Percent
Less than $15,000	329	31.4%	23,061	28.2%
15,000-24,999	298	28.4	21,473	26.2
25,000-34,999	154	14.7	13,244	16.2
35,000-49,999	153	14.6	12,922	15.8
50,000-74,999	81	7.7	6,667	8.1
75,000-99,999	16	1.5	1,830	2.2
100,000 or More	18	1.7	2,663	3.3
	1,049	100.0%	81,860	100.0

Assuming an average income of $17,500 for the 60% of the individuals in the two lower income brackets it is probably optimistic to think that they can afford to pay 5% more for insurance.

$17,500 x 5% = $875.00 Annually
or $223.13 Quarterly

This additional premium would still not bring the premiums for those issue ages 34 or under up to the community-rate.

Therefore, more than 50% of insured individuals could possibly join the uninsured ranks. If so, this would cause the community rate to go even higher since the younger individuals are dropping out.

There are currently 5,343 New Hampshire health policies in force.

CHART 4

NEW HAMPSHIRE PREMIUMS
Premium as % of Income
Age-Rated vs. Community-Rated

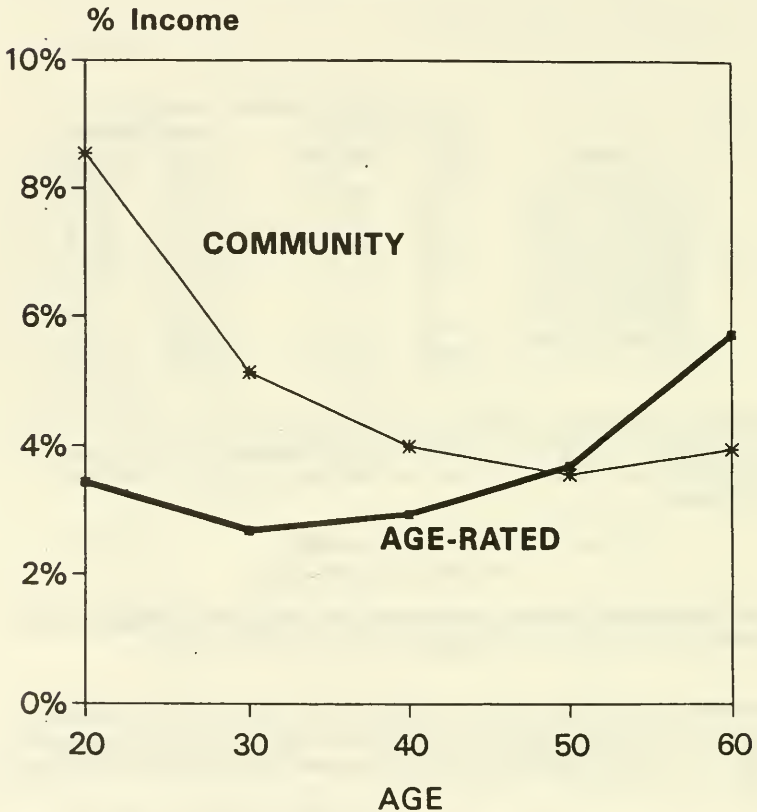
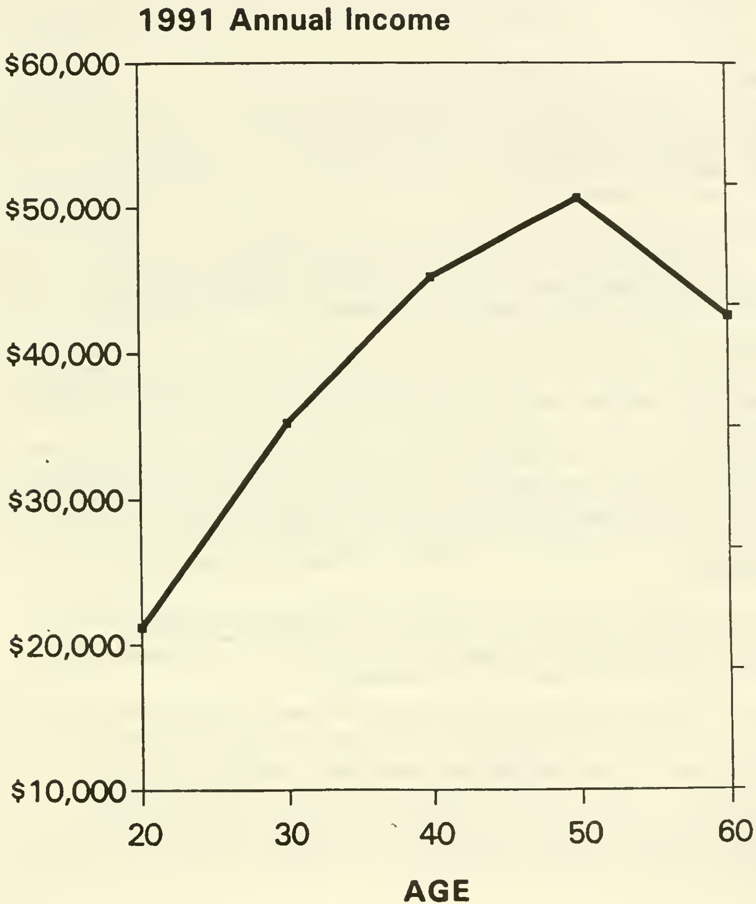


Illustration Zip 03801

CHART 5

Average Annual Income by Age



Source: 1993 U.S Abstact

37341
16270

The Senate of the State of New Hampshire
State House, Concord, 03301-4951

JEANNE SHAHEEN
District 21

Office 271-2117

TTY TDD
225-4033

April 14, 1994

John F. Mortell
Department of Insurance
311 West Washington Street
Suite 300
Indianapolis, Indiana 46204-2787

Dear Mr. Mortell,

I am writing to express my concern about the way Golden Rule Insurance Company, a carrier headquartered in Indiana, has sought to influence the debate about health care reform in New Hampshire.

Golden Rule writes a little more than one percent of health care policies in New Hampshire and returns only 54 percent of premiums paid in health care benefits. To protect its small but profitable market, the company has invested heavily to undermine support for legislation to reform health insurance.

Senate Bill 711 would introduce community rating, forbid medical underwriting, ensure guaranteed issue, eliminate pre-existing conditions and limit waiting periods. The legislation enjoys the support of those who together insure the majority of private individuals and small groups in the state as well as organizations representing management, labor and health care providers. As the prime sponsor of the bill, I am pleased by the support it has received from the Governor along with the commissioners of Health and Human Services and Insurance.

I do not question the right of Golden Rule to challenge this legislation, but I do question the outright lies and half-truths which have marked their direct mail and radio advertising campaigns. I enclose copies of the letters Golden Rule has sent to its agents and policyholders.

To rally support against community rating, the company alleges that in New York rates jumped 170 percent after its introduction. When challenged to support this claim, representatives of Golden Rule referred to an article which appeared in the New York Daily News before community rating was introduced. In any event, the experience of New York is irrelevant since Senate Bill 711 would introduce community rating over a four-year period during which annual rate increases would be limited to not more than 25 percent. Major carriers have indicated that with community rating rates would fall, not rise as Golden Rule claimed.

Golden Rule said that "government would determine what is fair in rates." But, Senate Bill would not change the mechanism or process for setting rates. Golden Rule said that "Those who do buy while they are healthy will subsidize those who wait until they are sick." But, Senate Bill 711 would establish a pre-existing waiting period of nine months for those without health insurance. Golden Rule said that "Availability of health insurance in New York also dried up," referring to Nationwide, Guardian, Metropolitan Life and Prudential. But, the Director of the Life and Health Division of the Department of Insurance for the state of New York assures me all these companies are still writing policies in New York.

I am very troubled that Golden Rule has devoted considerable resources to willful and blatant misrepresentations and distortions likely to arouse unwarranted anxiety and fear among the people of New Hampshire. In particular, I believe those who are insured by Golden Rule are very poorly served by the conduct of the company. My misgivings, echoed by others supporting Senate Bill 711 -- including insurance carriers and health care providers -- were forthrightly expressed at the public hearing attended by several representatives of Golden Rule.

I am sure you are aware that the National Association of Insurance Carriers has considered measures to overcome the kind of abuses committed by Golden Rule. I thought by sharing our concerns you might be better positioned to particpate in such efforts.

Thank you.

Sincerely yours,

Senator Jeanne C. Shaheen
District 21

STATE OF INDIANA

EVAN BAYH · Governor

IDOI

INDIANA DEPARTMENT OF INSURANCE
311 W. WASHINGTON STREET, SUITE 300
INDIANAPOLIS, INDIANA 46204-2787

JOHN F. MORTELL, Commissioner

April 27, 1994

State Senator Jeanne Shaheen
New Hampshire State House
Concord, N.H. 03301-4951

Re: Golden Rule Life Insurance Company

Dear State Senator Shaheen:

Commissioner Mortell recently left this Department to assume another position within state government, so I have been asked to respond to your letter to him of April 14, 1994 commenting on the lobbying activities of Golden Rule Life Insurance Company.

This Department is well aware of the lobbying practices that Golden Rule sometimes has employed in other states in response to health insurance reform legislation. However, like you, this Department takes the position that Golden Rule certainly has the right to challenge any legislation.

Your comments on the methods Golden Rule uses to challenge the legislation are well taken, but I think you will find, in looking at their efforts nationally, that Golden Rule has not been that successful in persuading legislators to its particular point of view.

I also would note that while the administrative offices of Golden Rule are located in Indianapolis, Indiana, the company is an Illinois domiciled company, having been established in Lawrenceville, Illinois.

Very truly yours,

David B. Reddick

David B. Reddick
Chief Deputy Commissioner

ADMINISTRATIVE SERVICES (317) 232-2385 · AGENCY SERVICES (317) 232-2389 · COMPANY SERVICES (317) 232-2397 · CONSUMER SERVICES (317) 232-2395 · EXAMINATIONS / FINANCIAL SERVICES (317) 232-2390

The Senate of the State of New Hampshire

State House, Concord, 03301-4951

JEANNE SHAHEEN
District 21

Office 271-2117

TTY/TDD
225-4033

May 2, 1994

Jeff Howard
Attorney General
State of New Hampshire
Concord, New Hampshire 03301

Dear Jeff:

Attached please find a letter I received on Saturday from Golden Rule Insurance Company. I have also forwarded a copy to the Senate Legal Counsel.

Could you please advise me if I should take any action in response to the letter?

Thank you.

Sincerely,

Jeanne

C. Jeanne Shaheen
State Senate District 21

Enclosures

CJS/aed

EDGAR R. LANTIS

ATTORNEY AT LAW
ADMITTED IN INDIANA & MICHIGAN

5767 West 74th Street
Indianapolis, Indiana 46278

(317) 291-3654
Fax (317) 291-0696
Home (317) 578-7677

April 27, 1994

Senator C. Jeanne Shaheen
73 Perkins Road
Madbury, NH 03820

Re: Public Comments Regarding Golden Rule Insurance Company on April 21, 1994

Dear Senator:

This office represents the interests of Golden Rule Insurance Company, an Illinois corporation authorized to transact the business of insurance in the State of New Hampshire.

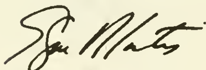
I have been asked to contact you regarding your comments before the House Commerce, Small Business' and Consumers Affairs Committee on Thursday, April 7, 1994. Your statements, as reported by the Foster's Democrat, include:

> "Golden Rule has resorted to lies and half-truths in an attempt in defeat this legislation;" and

> "These out-of-state hucksters could care less about New Hampshire's citizens, let alone their health. Far from following the golden rule, this company breaks all the rules to make sure the gold goes to their bottom line."

These statements are false, malicious and defamatory and as such represent libel per quod, if not libel per se. Similar future comments, if made outside the protective cocoon of legislative chambers may be actionable and appropriate for consideration by a court of competent jurisdiction.

Sincerely,



Edgar R. Lantis

ERL:lsa

cc: Suzanne E. Katt
Garry Rayno

c:\N-Hampshire\L.f\Shaheen.1

DEPARTMENT OF JUSTICE
STATE OF NEW HAMPSHIRE
25 CAPITOL STREET
CONCORD, NEW HAMPSHIRE 03301-6397

JEFFREY R. HOWARD
ATTORNEY GENERAL

GEORGE DANA BISBEE
DEPUTY ATTORNEY GENERAL

May 6, 1994

The Honorable C. Jeanne Shaheen
State Senate, District 21
State House, Room 304-A
Concord, New Hampshire 03301-4951

Dear Senator Shaheen:

This will acknowledge your letter of May 2, 1994, regarding correspondence you received from an attorney representing the Golden Rule Insurance Company. Based upon the information available to us, we would anticipate participating on your behalf in the event a legal claim is brought against you for the statements you made at a legislative committee hearing.

I would be happy to discuss this matter with you at your convenience.

Very truly yours,

Jeffrey R. Howard
Attorney General

JRH/der

Telephone 603-271-3658 • FAX 603-271-2110 • TDD Access: Relay NH 1-800-735-2964

Rep. Packard

MILLIMAN & ROBERTSON, INC.
Actuaries and Consultants

Suite 400
15700 Bluemound Road
Brookfield, Wisconsin 53005-6069
Telephone: 414/784-2250
Fax: 414/784-6388

Gerald R. Bernstein, F.S.A.
Stephen D. Brink, F.S.A.
Brian Z. Brown, F.C.A.S.
Mark J. Cain, A.C.A.S.
Susan J. Comerick, F.S.A., F.C.A.S.
Timothy D. Courtney, A.S.A.
Thomas K. Castle, F.S.A.
Patrick J. Dunks, A.S.A.
Pamela J. Evans, A.S.A.
Daniel J. Flaherty, F.C.A.S.
Steven G. Hanson, A.S.A.
Richard H. Hauboldt, F.S.A.
Peggy L. Hauser, F.S.A.
Gregory N. Herrle, F.S.A.
William V. Hogan, F.S.A.
Gary R. Josephson, F.C.A.S.
Frank Kopenski, Jr., A.S.A.
Kenneth E. Leinbach, F.S.A.
Mark E. Litow, F.S.A.
Elaine Magrady, A.S.A.
Sandra A. Mertes, F.S.A.
James C. Modaff, F.S.A.
Kenneth W. Newhouse, A.S.A.
David F. Ogden, F.S.A.
William M. Pollock, F.S.A.
Kevin B. Robbins, F.C.A.S.
Robert L. Sanders, F.C.A.S.
Steven J. Sherman, F.S.A.
John B. Snyder, F.S.A.
Lee H. Strunk, F.S.A.
Peter G. Wick, A.C.A.S.
Roger A. Yard, A.C.A.S.

Wendell Milliman, F.S.A. (1976)
Stuart A. Robertson, F.S.A.
Chairman Emeritus

April 27, 1994

Mr. Neal Chaplin
Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, IN 46278-1719

Re: **Estimated Impact of New Hampshire Bill 711 on Number of Uninsured Individuals and Cost**

Dear Mr. Chaplin

We have developed estimates of the population and costs in New Hampshire before and after implementation of the above referenced bill. Our estimates focus on the impact on the uninsured, Medicaid, individual and small group markets from 1995-1997. This bill may also have some peripheral impact on the large group market, but such effects are likely to be small and are therefore omitted.

In general, our analysis shows that with no other changes in the health care system, including no growth or cost increases from 1994 levels, the reforms in Bill 711 will likely produce more uninsureds and a higher cost for those with insurance. Further, a small increase in Medicaid recipients is anticipated. Shown below is our best estimate of population and costs for 1994-1997, where 1994 is before reform and 1995-1997 represent the implementation of the bill as specified therein.

Albany • Atlanta • Boston • Chicago • Cincinnati • Dallas • Denver • Hartford • Houston
Indianapolis • Irvine • Los Angeles • Milwaukee • Minneapolis • New York • Omaha • Philadelphia • Phoenix
Portland • St. Louis • Salt Lake City • San Diego • San Francisco • Seattle • Tokyo • Washington, D.C.

Internationally WOODROW MILLIMAN
Australia • Austria • Belgium • Bermuda • Canada •

Mr. Neal Chaplin
April 27, 1994
Page 2

Analysis of New Hampshire Senate Bill 711 Best Estimate of Population at 1994 Levels					
Market Segment	1994	1995	1996	1997	Percent Change 1994 to 1997
Individual	93,019	78,764	73,094	69,061	-25.8%
Small Group	222,788	194,655	182,754	174,295	-21.8%
Uninsured	154,614	196,525	213,893	226,237	46.3%
Medicaid*	50,965	51,442	51,645	51,793	1.6%
Total	521,386	521,386	521,386	521,386	0.0%

* These estimates represent the number of people covered on an annual exposed basis. Since recipients are often covered for less than 12 months, recipient counts will be higher.

Analysis of New Hampshire Senate Bill 711 Best Estimate of Annual Cost per Person at 1994 Levels					
Market Segment	1994	1995	1996	1997	Percent Change 1994 to 1997
Individual	$1,486	$1,636	$1,702	$1,752	17.9%
Small Group	1,440	1,522	1,559	1,587	10.2%
Uninsured	859	778	759	748	-12.9%
Medicaid*	8,023	8,011	8,008	8,007	-0.2%

* Includes vendor payments only. Disproportionate Share Hospital payments are not included. All costs are per exposed individual on an annual basis.

Mr. Neal Chaplin
April 27, 1994
Page 3

Analysis of New Hampshire Senate Bill 711 Best Estimate of Total Costs at 1994 Levels In Millions					
Market Segment	**1994**	**1995**	**1996**	**1997**	**Percent Change 1994 to 1997**
Individual	$138.2	$128.9	$124.4	$121.0	-12.4%
Small Group	320.8	296.3	284.9	276.6	-13.8%
Uninsured	132.8	152.9	162.3	169.2	+27.4%
Medicaid*	408.9	412.1	413.6	414.7	+1.4%

* Includes vendor payments only. Disproportionate Share Hospital payments are not included.

Because the impact of reform and its interaction with the marketplace and parts of the economy are difficult to estimate even with the best of data we have also tested other scenarios. These scenarios indicate that a reasonable range of the changes that may occur in 1995-1997 relative to 1994 results might be as follows:

	Population Change	**Cost per Person Change**
Individual	15%-35% Decrease	10%-25% Increase
Small Group	15%-30% Decrease	5%-15% Increase
Uninsured	30%-60% Increase	10%-15% Decrease
Medicaid	0%-5% Increase	0% - 1% Decrease

Our inclusion of these scenarios does not preclude the use of other reasonable scenarios, some of which may produce values outside of the ranges we have shown. However, we do believe the ranges shown are representative of scenarios having the highest probability of occurring.

The starting point for the assumptions underlying the above estimates is the M&R national database for 1994. This database is developed from the 1994 Milliman & Robertson, Inc. Health Cost Guidelines, Medicaid Statistics as published by the Department of Health and Human

Mr. Neal Chaplin
April 27, 1994
Page 4

Services, The Statistical Abstract of the United States, several reports as published by the Employers Benefit Research Institute, and data from the Health Care Financing Administration.

Underlying the aggregate values in the tables above are populations and costs by age and sex and health status. Age categories used per adult are 18-34, 35-49, and 50-64. Children are combined with the adults according to household status (i.e. single, one parent family, etc.). Health statuses used are *Healthy* (morbidity less than 90% of average), *Slightly Impaired* (morbidity between 90 and 150% of average), *Significantly Impaired* (morbidity between 150 and 350% of average), and *Uninsurable* (morbidity above 350%).

Population and cost relativities by age and health status in New Hampshire are assumed to be the same as estimated per our national database. However, because Medicaid costs per person are quite high in New Hampshire, we believe the slope of cost by health status are not as steep as shown (healthy costs are likely underestimated and uninsured costs are likely overestimated). Nonetheless, changing the slope of Medicaid morbidity by health status would have little if any effect on results.

Values for 1995-1997 after reform reflect the estimated impact of the bill as written without any population growth or cost trends. In general, these reforms include guaranteed issue, modified community rating wherein premiums may vary by age by as much as four times in 1995, three times in 1996 and two times in 1997, and a rate increase limitation of 25% per year without regard to inflation. Further, these reforms are assumed to be applicable to all individual and small group business (less than 100 employees).

The scenarios tested reflect the impact of choices available to individuals or families including the cost of insurance, their health status, available income, becoming uninsured and taking that risk, or moving onto the Medicaid rolls if income levels allow that. In other words, the estimates only reflect the anticipated movement of the population in 1995 -1997 as follows:

- Uninsureds entering the Individual or Small Group Market: This event may only occur if i) the cost of coverage (premium) has been reduced, such as often occurs for older age individuals or groups under forms of community rating, or ii) significantly impaired or uninsurable individuals or high risk small groups can purchase coverage they were unable to purchase before reform (due to guaranteed issue).

- Individual or small group market participants exiting the market: This event occurs if the cost of the insurance increases to the point where people determine that they can no longer afford the cost in relation to their income or do not see sufficient value in the

coverage to justify the cost. In some cases, these people may be able to enroll in Medicaid, but most will become uninsured.

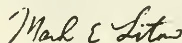
Exhibit 1 shows the assumptions relative to estimated events by market for each scenario. Low movement means that assumptions relative to the best estimate either decrease or stay the same. High movement means that assumptions relative to the best estimate either increase or stay the same.

All people on Medicaid, and those who are uninsured and do not enter the individual or small group markets, are assumed to remain with the same group since other alternatives (outside the scope of Bill 711) are not assumed to be available. Also, Medicaid costs in this report reflect vendor payments only, unless otherwise noted. Non-vendor payments in New Hampshire are very high relative to the average nationwide, and inclusion of these will produce much higher costs.

Additional limitations and caveats to the findings in this report are included in Exhibit 2.

If you have any questions or would like additional information, please call.

Sincerely,



Mark E. Litow, F.S.A.
Consulting Actuary

MEL/dyj

Attachments

cc: Suzy Katt
John Hartnedy

Exhibit 1 - Page 1

Analysis of New Hampshire Senate Bill 711
Best Estimate Assumptions for Percentages Moving Between Markets

Percent Leaving Individual Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	25.00%	12.50%	2.00%	1.00%
35-49	15.00%	7.50%	1.00%	1.00%
50-64	10.00%	5.00%	1.00%	1.00%

Percent of Uninsured Entering Individual Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.00%	10.00%	25.00%
35-49	0.00%	1.00%	10.00%	25.00%
50-64	0.00%	2.00%	10.00%	25.00%

Percent of Those Leaving Individual Market in 1995 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.00%	4.00%	7.00%	10.00%
35-49	1.00%	4.00%	7.00%	10.00%
50-64	1.00%	4.00%	7.00%	10.00%

Percent Leaving Small Group Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	20.00%	10.00%	2.00%	1.00%
35-49	12.00%	6.00%	1.00%	1.00%
50-64	8.00%	4.00%	1.00%	1.00%

Percent of Uninsured Entering Small Group Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.00%	10.00%	25.00%
35-49	0.00%	1.00%	10.00%	25.00%
50-64	0.00%	2.00%	10.00%	25.00%

Percent of Those Leaving Small Group Market in 1995 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.00%	1.00%	2.00%	2.00%
35-49	1.00%	1.00%	2.00%	2.00%
50-64	1.00%	1.00%	2.00%	2.00%

Exhibit 1 - Page 2

Analysis of New Hampshire Senate Bill 711
Best Estimate Assumptions for Percentages Moving Between Markets

Percent Leaving Individual Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	12.50%	6.25%	2.00%	1.00%
35-49	7.50%	3.75%	1.00%	1.00%
50-64	5.00%	2.50%	1.00%	1.00%

Percent of Uninsured Entering Individual Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.00%	6.00%	15.00%
35-49	0.00%	1.00%	6.00%	15.00%
50-64	0.00%	2.00%	6.00%	15.00%

Percent of Those Leaving Individual Market in 1996 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.00%	4.00%	7.00%	10.00%
35-49	1.00%	4.00%	7.00%	10.00%
50-64	1.00%	4.00%	7.00%	10.00%

Percent Leaving Small Group Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	10.00%	5.00%	2.00%	1.00%
35-49	6.00%	3.00%	1.00%	1.00%
50-64	4.00%	2.00%	1.00%	1.00%

Percent of Uninsured Entering Small Group Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.00%	6.00%	15.00%
35-49	0.00%	1.00%	6.00%	15.00%
50-64	0.00%	2.00%	6.00%	15.00%

Percent of Those Leaving Small Group Market in 1996 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.00%	1.00%	2.00%	2.00%
35-49	1.00%	1.00%	2.00%	2.00%
50-64	1.00%	1.00%	2.00%	2.00%

Exhibit 1 - Page 3

Analysis of New Hampshire Senate Bill 711
Best Estimate Assumptions for Percentages Moving Between Markets

Percent Leaving Individual Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	12.50%	5.00%	2.00%	1.00%
35-49	3.75%	3.00%	1.00%	1.00%
50-64	2.50%	2.00%	1.00%	1.00%

Percent of Uninsured Entering Individual Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.00%	4.00%	10.00%
35-49	0.00%	1.00%	4.00%	10.00%
50-64	0.00%	2.00%	4.00%	10.00%

Percent of Those Leaving Individual Market in 1997 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.00%	4.00%	7.00%	10.00%
35-49	1.00%	4.00%	7.00%	10.00%
50-64	1.00%	4.00%	7.00%	10.00%

Percent Leaving Small Group Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	10.00%	4.00%	2.00%	1.00%
35-49	3.00%	2.50%	1.00%	1.00%
50-64	2.00%	1.50%	1.00%	1.00%

Percent of Uninsured Entering Small Group Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.00%	4.00%	10.00%
35-49	0.00%	1.00%	4.00%	10.00%
50-64	0.00%	2.00%	4.00%	10.00%

Percent of Those Leaving Small Group Market in 1997 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.00%	1.00%	2.00%	2.00%
35-49	1.00%	1.00%	2.00%	2.00%
50-64	1.00%	1.00%	2.00%	2.00%

Exhibit 1 - Page 4

Analysis of New Hampshire Senate Bill 711
High Movement Assumptions for Percentages Moving Between Markets

Percent Leaving Individual Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	35.00%	17.50%	2.50%	1.50%
35-49	22.50%	10.00%	1.50%	1.50%
50-64	15.00%	7.50%	1.50%	1.50%

Percent of Uninsured Entering Individual Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.50%	14.00%	35.00%
35-49	0.00%	1.50%	14.00%	35.00%
50-64	0.00%	2.50%	14.00%	35.00%

Percent of Those Leaving Individual Market in 1995 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.50%	5.00%	8.00%	12.00%
35-49	1.50%	5.00%	8.00%	12.00%
50-64	1.50%	5.00%	8.00%	12.00%

Percent Leaving Small Group Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	28.00%	14.00%	2.50%	1.50%
35-49	18.00%	8.00%	1.50%	1.50%
50-64	12.00%	6.00%	1.50%	1.50%

Percent of Uninsured Entering Small Group Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.50%	14.00%	35.00%
35-49	0.00%	1.50%	14.00%	35.00%
50-64	0.00%	2.50%	14.00%	35.00%

Percent of Those Leaving Small Group Market in 1995 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.50%	1.50%	2.50%	2.50%
35-49	1.50%	1.50%	2.50%	2.50%
50-64	1.50%	1.50%	2.50%	2.50%

Exhibit 1 - Page 5

Analysis of New Hampshire Senate Bill 711
High Movement Assumptions for Percentages Moving Between Markets

Percent Leaving Individual Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	17.50%	7.50%	2.50%	1.50%
35-49	10.00%	5.00%	1.50%	1.50%
50-64	7.50%	3.75%	1.50%	1.50%

Percent of Uninsured Entering Individual Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.50%	9.00%	25.00%
35-49	0.00%	1.50%	9.00%	25.00%
50-64	0.00%	2.50%	9.00%	25.00%

Percent of Those Leaving Individual Market in 1996 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.50%	5.00%	8.00%	12.00%
35-49	1.50%	5.00%	8.00%	12.00%
50-64	1.50%	5.00%	8.00%	12.00%

Percent Leaving Small Group Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	14.00%	6.00%	2.50%	1.50%
35-49	8.00%	4.00%	1.50%	1.50%
50-64	6.00%	3.00%	1.50%	1.50%

Percent of Uninsured Entering Small Group Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.50%	10.00%	25.00%
35-49	0.00%	1.50%	10.00%	25.00%
50-64	0.00%	2.50%	10.00%	25.00%

Percent of Those Leaving Small Group Market in 1996 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.50%	1.50%	2.50%	2.50%
35-49	1.50%	1.50%	2.50%	2.50%
50-64	1.50%	1.50%	2.50%	2.50%

Exhibit 1 - Page 6

Analysis of New Hampshire Senate Bill 711
High Movement Assumptions for Percentages Moving Between Markets

Percent Leaving Individual Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	17.50%	6.25%	2.50%	1.50%
35-49	5.00%	4.00%	1.50%	1.50%
50-64	3.75%	3.00%	1.50%	1.50%

Percent of Uninsured Entering Individual Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.50%	6.00%	15.00%
35-49	0.00%	1.50%	6.00%	15.00%
50-64	0.00%	2.50%	6.00%	15.00%

Percent of Those Leaving Individual Market in 1997 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.50%	5.00%	8.00%	12.00%
35-49	1.50%	5.00%	8.00%	12.00%
50-64	1.50%	5.00%	8.00%	12.00%

Percent Leaving Small Group Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	14.00%	5.00%	2.50%	1.50%
35-49	4.00%	3.50%	1.50%	1.50%
50-64	3.00%	2.50%	1.50%	1.50%

Percent of Uninsured Entering Small Group Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	1.50%	6.00%	15.00%
35-49	0.00%	1.50%	6.00%	15.00%
50-64	0.00%	2.50%	6.00%	15.00%

Percent of Those Leaving Small Group Market in 1997 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	1.50%	1.50%	2.50%	2.50%
35-49	1.50%	1.50%	2.50%	2.50%
50-64	1.50%	1.50%	2.50%	2.50%

Exhibit 1 - Page 7

Analysis of New Hampshire Senate Bill 711
Low Movement Assumptions for Percentages Moving Between Markets

Percent Leaving Individual Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	15.00%	7.50%	1.50%	0.50%
35-49	7.50%	5.00%	0.50%	0.50%
50-64	5.00%	2.50%	0.50%	0.50%

Percent of Uninsured Entering Individual Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	0.50%	6.00%	15.00%
35-49	0.00%	0.50%	6.00%	15.00%
50-64	0.00%	1.50%	6.00%	15.00%

Percent of Those Leaving Individual Market in 1995 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.50%	3.00%	6.00%	8.00%
35-49	0.50%	3.00%	6.00%	8.00%
50-64	0.50%	3.00%	6.00%	8.00%

Percent Leaving Small Group Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	12.00%	6.00%	1.50%	0.50%
35-49	6.00%	4.00%	0.50%	0.50%
50-64	4.00%	2.00%	0.50%	0.50%

Percent of Uninsured Entering Small Group Market in 1995

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	0.50%	6.00%	15.00%
35-49	0.00%	0.50%	6.00%	15.00%
50-64	0.00%	1.50%	6.00%	15.00%

Percent of Those Leaving Small Group Market in 1995 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.50%	0.50%	1.50%	1.50%
35-49	0.50%	0.50%	1.50%	1.50%
50-64	0.50%	0.50%	1.50%	1.50%

Exhibit 1 - Page 8

Analysis of New Hampshire Senate Bill 711
Low Movement Assumptions for Percentages Moving Between Markets

Percent Leaving Individual Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	7.50%	5.00%	1.50%	0.50%
35-49	5.00%	2.50%	0.50%	0.50%
50-64	2.50%	1.25%	0.50%	0.50%

Percent of Uninsured Entering Individual Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	0.50%	3.00%	5.00%
35-49	0.00%	0.50%	3.00%	5.00%
50-64	0.00%	1.50%	3.00%	5.00%

Percent of Those Leaving Individual Market in 1996 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.50%	3.00%	6.00%	8.00%
35-49	0.50%	3.00%	6.00%	8.00%
50-64	0.50%	3.00%	6.00%	8.00%

Percent Leaving Small Group Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	6.00%	4.00%	1.50%	0.50%
35-49	4.00%	2.00%	0.50%	0.50%
50-64	2.00%	1.00%	0.50%	0.50%

Percent of Uninsured Entering Small Group Market in 1996

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	0.50%	2.00%	5.00%
35-49	0.00%	0.50%	2.00%	5.00%
50-64	0.00%	1.50%	2.00%	5.00%

Percent of Those Leaving Small Group Market in 1996 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.50%	0.50%	1.50%	1.50%
35-49	0.50%	0.50%	1.50%	1.50%
50-64	0.50%	0.50%	1.50%	1.50%

Exhibit 1 - Page 9

Analysis of New Hampshire Senate Bill 711
Low Movement Assumptions for Percentages Moving Between Markets

Percent Leaving Individual Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	7.50%	3.75%	1.50%	0.50%
35-49	2.50%	2.00%	0.50%	0.50%
50-64	1.25%	1.00%	0.50%	0.50%

Percent of Uninsured Entering Individual Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	0.50%	2.00%	5.00%
35-49	0.00%	0.50%	2.00%	5.00%
50-64	0.00%	1.50%	2.00%	5.00%

Percent of Those Leaving Individual Market in 1997 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.50%	3.00%	6.00%	8.00%
35-49	0.50%	3.00%	6.00%	8.00%
50-64	0.50%	3.00%	6.00%	8.00%

Percent Leaving Small Group Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	6.00%	3.00%	1.50%	0.50%
35-49	2.00%	1.50%	0.50%	0.50%
50-64	1.00%	0.50%	0.50%	0.50%

Percent of Uninsured Entering Small Group Market in 1997

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.00%	0.50%	2.00%	5.00%
35-49	0.00%	0.50%	2.00%	5.00%
50-64	0.00%	1.50%	2.00%	5.00%

Percent of Those Leaving Small Group Market in 1997 Who Enroll in Medicaid

Age	Healthy	Slightly Impaired	Significantly Impaired	Uninsurable
Under 35	0.50%	0.50%	1.50%	1.50%
35-49	0.50%	0.50%	1.50%	1.50%
50-64	0.50%	0.50%	1.50%	1.50%

Exhibit 2

Limitations on Findings

1. Estimates assume guaranteed issue and renewability are required for all policies inforce and those to be issued, with effectively no pre-existing conditions limitations in place. In this case, guaranteed issue means that people have an annual enrollment period during which no underwriting for any type can occur for at least 60 days in duration.

2. Community rating assumes rates can vary by membership type (i.e. single, two person, family) and by age as noted in the report and that such rates are guaranteed for a period of at least six months. Other risk factors such as health status, gender, geographical location, occupation, claim experience and occupation may not be considered (for a full list of factors see Bill 711).

3. Estimates are based on starting point values and assumptions as specified for a particular scenario. Changes in the starting point or assumptions will likely change the results to varying degrees.

4. All results represent averages under a specific scenario, whether in total or for a particular group. However, particular people in a group may not conform to the average and may have a very different result.

5. Under this reform, some people (those uninsured who are unhealthy) will have access to a choice which does not exist for them today. Others will have a choice taken away because they can no longer afford to buy any type of coverage. These changes cannot be predicted with any certainty by individual, but can be predicted within a range for groups with similar characteristics.

6. Children are included with the adults group according to the family group or household in which they live. Distinct estimates by household could produce a more finely-tuned result which could, but is not likely to be, materially different from those shown.

7. Similarly, as in #6, other assumptions could be fine-tuned, such as more age/sex cells. However, we do not anticipate results with only this change would be materially different from those shown.

April 27, 1994

Exhibit 2 - Page 2

8. The degree of stability in the various markets among carriers and policyholders after the introduction of provisions in Bill 711 could be significantly affected by consistency in rate levels and rating practices among these carriers.

9. Average rates among carriers can be expected to differ both before and after reform, but less variation is likely after reform.

10. Changes in the number of uninsured persons due to these legislative provisions cannot be predicted with certainty. The short term impact may be significantly affected by precipitous, dramatic changes in carrier rate levels.

Potential changes in the number of uninsured, impacts on relationships in private market rate levels and other effects can be meaningfully analyzed through testing of multiple scenarios. The use of multiple scenarios is necessary because of the large number of actuarial and market assumptions that must be made, as well as assumptions regarding carrier behavior.

April 27, 1994

The Senate of the State of New Hampshire

State House, Concord, 03301-4951

JEANNE SHAHEEN
District 21

Office 271-2117

TTY TDD
225-4033

May 19, 1994

Commissioner Sylvio Dupuis
New Hampshire Insurance Department
169 Manchester Street
Concord, NH 03301

Dear Commissioner Dupuis,

We are writing to make a formal request that the Insurance Department investigate the actions taken by Golden Rule Insurance Company in its efforts to prevent passage of Senate Bill 711, the Small Employer Health Care Insurance Reform Act.

We have enclosed a number of documents, including mailings and testimony prepared by the company, which we believe represent a knowing and willful effort to mislead both private citizens and public officials about the merits of the legislation. We have also enclosed other supporting materials to lend direction to any inquiries the department may pursue.

When the veracity of the company's assertions was questioned, an attorney representing Golden Rule Insurance Company cautioned Senator Shaheen, warning that the company deemed the remarks libellous and could take legal action. We have also enclosed correspondence, including an exchange of letters between Senator Shaheen and the Attorney General, documenting this aspect of the affair.

We believe mailings sent by the company to brokers and policyholders were designed to sow fear and anxiety among private citizens and public officials alike by misrepresenting the likely consequences of the legislation. In particular, we call your attention to the letter sent to brokers and policyholders on April 1st which claimed that similar legislation led to rate increases of 170 percent in New York. The company offered an article from the New York Daily News of March 10, 1993 in support of its claim. When it was demonstrated that the article appeared before insurance reform was undertaken in New York and that the New York Department of Insurance had not approved rate increases of this magnitude, the company tempered its claim in a subsequent mailing on April 25th.

Furthermore, we would respectfully suggest that any inquiry include an effort to determine whether or not Golden Rule Insurance Company conducted itself in compliance with the statutes and rules, including reporting requirements, which govern lobbying in New Hampshire.

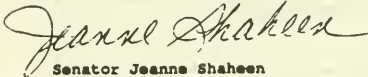
We do not question the right of companies like Golden Rule Insurance Company to participate in the legislative process. On the contrary, we are accustomed to working closely with private companies as well as other interests as we draft, amend and adopt legislation. And, for the most part, we welcome the contributions made by private companies, trade associations, professional organizations and public interest groups to the process.

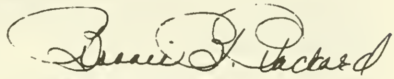
However, we believe that Golden Rule Insurance Company, by blatantly misrepresenting the legislation and crudely threatening its sponsor, breached the bounds of propriety. We are confident that a formal inquiry would confirm our judgment of the company and trust that its findings might lead to appropriate sanctions to discourage similar conduct in the future.

We understand that the National Association of Insurance Commissioners has expressed concern at the lobbying tactics pursued by some insurance carriers in their zeal to safeguard their interests amid reforms of our health care system. We hope that a formal inquiry into the conduct of Golden Rule Insurance Company in New Hampshire might provide guidance to the commissioners as they address this issue.

Thank you for considering our request. Needless to say, should you decide to pursue this matter further, we will pleased to do whatever we can to assist the department.

Sincerely yours,





Senator Jeanne Shaheen
District 21

Representative Bonnie Packard
Hillsborough/19

The Senate of the State of New Hampshire
State House, Concord, 03301-4951

JEANNE SHAHEEN
District 21

Office 271-2117

TTY TDD
225-4033

May 19, 1994

Commissioner Sylvio Dupuis
New Hampshire Insurance Department
169 Manchester Street
Concord, NH 03301

Dear Commissioner Dupuis,

We are writing to make a formal request that the Insurance Department investigate the actions taken by Golden Rule Insurance Company in its efforts to prevent passage of Senate Bill 711, the Small Employer Health Care Insurance Reform Act.

We have enclosed a number of documents, including mailings and testimony prepared by the company, which we believe represent a knowing and willful effort to mislead both private citizens and public officials about the merits of the legislation. We have also enclosed other supporting materials to lend direction to any inquiries the department may pursue.

When the veracity of the company's assertions was questioned, an attorney representing Golden Rule Insurance Company cautioned Senator Shaheen, warning that the company deemed the remarks libellous and could take legal action. We have also enclosed correspondence, including an exchange of letters between Senator Shaheen and the Attorney General, documenting this aspect of the affair.

We believe mailings sent by the company to brokers and policyholders were designed to sow fear and anxiety among private citizens and public officials alike by misrepresenting the likely consequences of the legislation. In particular, we call your attention to the letter sent to brokers and policyholders on April 1st which claimed that similar legislation led to rate increases of 170 percent in New York. The company offered an article from the New York Daily News of March 10, 1993 in support of its claim. When it was demonstrated that the article appeared before insurance reform was undertaken in New York and that the New York Department of Insurance had not approved rate increases of this magnitude, the company tempered its claim in a subsequent mailing on April 25th.

Furthermore, we would respectfully suggest that any inquiry include an effort to determine whether or not Golden Rule Insurance Company conducted itself in compliance with the statutes and rules, including reporting requirements, which govern lobbying in New Hampshire.

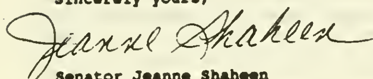
We do not question the right of companies like Golden Rule Insurance Company to participate in the legislative process. On the contrary, we are accustomed to working closely with private companies as well as other interests as we draft, amend and adopt legislation. And, for the most part, we welcome the contributions made by private companies, trade associations, professional organizations and public interest groups to the process.

However, we believe that Golden Rule Insurance Company, by blatantly misrepresenting the legislation and crudely threatening its sponsor, breached the bounds of propriety. We are confident that a formal inquiry would confirm our judgment of the company and trust that its findings might lead to appropriate sanctions to discourage similar conduct in the future.

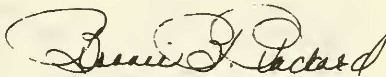
We understand that the National Association of Insurance Commissioners has expressed concern at the lobbying tactics pursued by some insurance carriers in their zeal to safeguard their interests amid reforms of our health care system. We hope that a formal inquiry into the conduct of Golden Rule Insurance Company in New Hampshire might provide guidance to the commissioners as they address this issue.

Thank you for considering our request. Needless to say, should you decide to pursue this matter further, we will pleased to do whatever we can to assist the department.

Sincerely yours,



Senator Jeanne Shaheen
District 21



Representative Bonnie Packard
Hillsborough/19

Sylvia L. Dupuis, OD
Commissioner

The State of New Hampshire

Insurance Department
169 Manchester St. Ste 1
Concord, N.H. 03301-5151
603-271-2261

June 9, 1994

The Honorable C. Jeanne Shaheen
State Senate, District 21
State House, Room 304-A
Concord, New Hampshire 03301-4951

Dear Senator Shaheen:

Enclosed is a copy of a memo from Assistant Commissioner, David Nichols, regarding your request to explore what action which this Department might initiate as a result of the activities of the Golden Rule Insurance Company. He has, as indicated, worked with the Attorney General's office and researched our own statutes and regulations prior to reaching his conclusion. I have also discussed the matter with him at some length.

I am very pleased at the outcome of the legislative process, and while I share your concern for the actions of Golden Rule, I hope we can find enough satisfaction in serving the public interest to put this matter behind us. I intend to meet with senior officials at Golden Rule to express my displeasure of their actions particularly as they related to you personally.

Thanks for your continuing service to the people of our State.

Cordially,

Sylvia L. Dupuis, OD
Commissioner

SLD:slb

enclosure

STATE OF NEW HAMPSHIRE

Inter-Department Communication

DATE June 6, 1994

FROM David Nichols
Assistant Commissioner

AT (OFFICE) Administrative Division

SUBJECT **Golden Rule Complaint**

TO Sylvio L. Dupuis, OD
Commissioner

You have requested an opinion regarding the complaint against Golden Rule filed with this office by Senator Shaheen and Representative Packard on May 23, 1994.

The complaint focuses on two areas which Senator Shaheen and Representative Packard feel action by Golden Rule may in be violation of New Hampshire law.

The first suggests the possibility that Golden Rule violated the rules governing lobbying in this State. I have contacted the Attorney General's Office regarding this issue and have been informed that they have received a complaint on this matter which they are currently pursuing. It would appear that the Attorney General's Office is the appropriate department to investigate this portion of the complaint.

The second concern is more general in nature and involves the activities of Golden Rule surrounding their dissemination of information relative to SB711. The complaint alleges that Golden Rule misrepresented certain facts related to the possible effects of SB711.

I have reviewed the insurance statutes for a possible violation. It would appear that title XXXVII does not contain any prohibition of the activities in question. Although I would personally agree with Senator Shaheen and Representative Packard that Golden Rule's use of information in this process left much to be desired, especially with regard to their comparison with the effects of reform in New York and their estimates of the effects on consumers in New Hampshire, no specific statute seems to have been violated.

DN:man

The Senate of the State of New Hampshire
State House, Concord, 03301-4951

C. JEANNE SHAHEEN
District 21

Office 271-2117

TTY TDD
225-4033

May 27, 1994

The Honorable Jeffrey R. Howard
New Hampshire Attorney General
Department of Justice
25 Capitol Street
Concord, NH 03301

Dear Attorney General Howard:

I have reason to believe that the financial statements filed by registered lobbyists representing Golden Rule Insurance Company may not be in compliance with RSA 15:3.

I would be grateful if, in accordance with RSA 15:6, you would examine these financial statements and determine whether they comply with state law.

Please find copies of the statements filed on April 15 enclosed.

Thank you.

Sincerely yours,

C. Jeanne Shaheen
Senator, District 21

CJS
Enclosure

RECEIVED
APR 11 1994
NEW HAMPSHIRE
SECRETARY OF STATE

LOBBYIST: JULIA RENEE NEUNABER
EMPLOYED BY:
LOBBYING FOR: GOLDEN RULE INSURANCE

DATE OF REPORT
1994 Session
April 15 XXX
(Date of Reg.-Apr
August 15 ___
(Apr. 1 - Aug. 1)
December 15 ___
(Aug 1 - Dec. 1)

LEGISLATIVE COUNSEL, AGENT OR EMPLOYEE STATEMENT OF FEES & EXPENDITURES RSA 15

A. LOBBYIST FEES. Include all amounts of money and/or equivalent thing of value you received or contracted to receive for your lobbying activities since the time of your registration or last report, whichever was later. Pro-rate your salary if it includes compensation for lobbying activities.

$ 937.50 (list itemizations on back of this form) $ 937.50 total fees to date

B. EXPENDITURES MADE DIRECTLY BY LOBBYIST. Include amount of money and/or description of things of value paid by you or contracted to be paid by you for your lobbying efforts since the time of your registration or last report, whichever was later. Itemize all expenditures over $25. and aggregrate those expenditures of lesser amounts.

$ ______ (list itemizations on back of this form) $ ______ total expenditures to date

C. LOBBYIST EXPENDITURES CHARGED BY LOBBYIST TO EMPLOYER. Include amount of money and/or description of things of value to be paid by your employer in connection with your lobbying efforts since the time of your registration or last report, whichever was later. Itemize all expenditures over $25. and aggregrate those expenditures of lesser amounts.

$ 934.96 (list itemizations on back of this form) $ 934.96 total expenditures to date

I hereby swear that the foregoing is a true statement.

Julia Neunaber
Signature of Lobbyist

Return to: Dept. of State, State House, Rm. 204, Concord, NH 03301

ITEMIZED STATEMENT

A. ITEMIZED FEES

DATE RECEIVED	PAID BY WHOM (Name & Address)	AMOUNT OF FEE
Pro-Rated Salary		

B. ITEMIZED EXPENDITURES MADE DIRECTLY BY LOBBYIST

DATE PAID	PAID BY WHOM (Name & Address)	AMOUNT OF EXPENDITURE

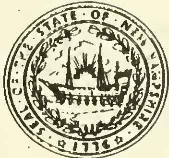
Total of unitemized expenditures ($25 or under) in this report $________

C. ITEMIZED EXPENDITURES CHARGED BY LOBBYIST TO EMPLOYER

DATE CHARGED	(Name & Address of Business Charged)	AMOUNT OF EXPENDITURE
2/15-2/17	Golden Rule Insurance 7440 Woodland Ave Indianapolis, IN	629.50 1.62 134.47 2.17 13.75 14.14 61.51 4.00 61.51 12.29

Total of unitemized expenditures ($25 or under) in this report $________

RECEIVED
APR 25 1994
NEW HAMPSHIRE
SECRETARY OF STATE



LOBBYIST: NEAL E. CHAPLIN
EMPLOYED BY:
LOBBYING FOR: GOLDEN RULE INSURANCE CO.

DATE OF REPORT
1994 Session
April 15 xxx
(Date of Reg.-Apr
August 15 ___
(Apr. 1 - Aug. 1)
December 15 ___
(Aug 1 - Dec. 1)

LEGISLATIVE COUNSEL, AGENT OR EMPLOYEE
STATEMENT OF FEES & EXPENDITURES
RSA 15

A. LOBBYIST FEES. Include all amounts of money and/or equivalent thing of value you received or contracted to receive for your lobbying activities since the time of your registration or last report, whichever was later. Pro-rate your salary if it includes compensation for lobbying activities.

$ ______ (list itemizations on back of this form) $ 476.36 total fees to date

B. EXPENDITURES MADE DIRECTLY BY LOBBYIST. Include amount of money and/or description of things of value paid by you or contracted to be paid by you for your lobbying efforts since the time of your registration or last report, whichever was later. Itemize all expenditures over $25. and aggregrate those expenditures of lesser amounts.

$ ______ (list itemizations on back of this form) $ -0- total expenditures to date

C. LOBBYIST EXPENDITURES CHARGED BY LOBBYIST TO EMPLOYER. Include amount of money and/or description of things of value to be paid by your employer in connection with your lobbying efforts since the time of your registration or last report, whichever was later. Itemize all expenditures over $25. and aggregrate those expenditures of lesser amounts.

$ ______ (list itemizations on back of this form) $1172.91 total expenditures to date

I hereby swear that the foregoing is a true statement.

Neal E. Chaplin
Signature of Lobbyist

Return to: Dept. of State, State House, Rm. 204, Concord, NH 03301

ITEMIZED STATEMENT

A. ITEMIZED FEES

DATE RECEIVED	PAID BY WHOM (Name & Address)	AMOUNT OF FEE
3/28/94	Golden Rule Insurance, 7440 Woodland Dr., Indpls., IN 46278	$119.09
3/29/94	" "	$119.09
3/30/94	" "	$119.09
3/31/94	" "	$119.09

B. ITEMIZED EXPENDITURES MADE DIRECTLY BY LOBBYIST

DATE PAID	PAID BY WHOM (Name & Address)	AMOUNT OF EXPENDITURE
		-0-

Total of unitemized expenditures ($25 or under) in this report $ -0-

C. ITEMIZED EXPENDITURES CHARGED BY LOBBYIST TO EMPLOYER

DATE CHARGED	(Name & Address of Business Charged)	AMOUNT OF EXPENDITURE
3/27/94	Golden Rule Insurance, 7440 Woodland Dr., Indpls., IN 46278	$790.76
3/28/94	" "	$148.51
3/29/94	" "	$110.42
3/30/94	" "	$99.72
3/31/94	"	$23.50

Total of unitemized expenditures ($25 or under) in this report $ ______

Golden Rule®

April 1, 1994

Dear Broker:

You are licensed with Golden Rule. That's why we are writing to you. You need to read this important information.

You must call your legislators today and tell them to oppose SB 711.

SB 711 will:

- Require Guaranteed Issue for the Small Group and Individual Markets; and

- Require a narrow form of Community Rating.

Guaranteed Issue means that your clients, who had the forethought and prudence to purchase health insurance in case they got sick, will no longer get the benefit of lower premiums. There will be no incentive to purchase health insurance while healthy. Those who do buy while healthy will get to subsidize those who wait until they're sick. That means higher premiums. This is really a new tax, and the legislature wants to hide it in the premiums of your clients.

The proposal would also require a form of Community Rating. We won't be able to use actual claim costs in calculating rates; we'll have to use the government's idea of what is fair.

The combination of Guaranteed Issue and Community Rating is explosive. When New York passed these reforms last year, the New York Department of Insurance approved rate increases for young families of 170%! Even families in which the policyholder was 45 years old received increases of 30%! Can your clients withstand these rate increases?

(over)

Golden Rule Insurance Company

Home Office
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439
Telephone (618) 943-8000

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

Jonathan Karl, co-founder of Third Millennium, recently wrote an editorial in the December 14, 1993, Indianapolis Star which said in part:

> "... Community rating may sound fine in theory, but in practice it forces the young (who have the least amount of disposable income) to subsidize the health care of the middle aged (who are at the peak of their earning power).
>
> This was made painfully clear this year in New York state, which just instituted the country's most rigid community rating plan. Most young New Yorkers saw their health care premiums skyrocket. For example, before community rating, the average 30-year-old single male paid a premium of $1,200; after the change, his premium soared to $3,240. Likewise, young families saw their premiums nearly double.
>
> The only age group that benefited from the changes in New York was the over-50 bracket. For example, the average 60-year-old male saw his annual premiums go from $5,880 to $3,240, a decrease of nearly 50 percent. But the cost of reducing the premiums for the wealthiest segment of the population was high: It put the price of health care out of reach for many young New Yorkers just entering the work force...."

Golden Rule®

Senator C. Jeanne Shaheen
73 Perkins Road
Madbury, NH 03820

April 20, 1994

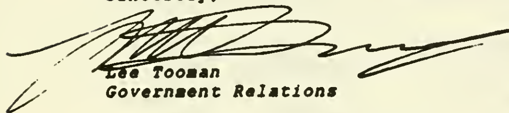
Dear Senator Shaheen:

Earlier this month, I wrote to our policyholders about the effects of SB 711. Apparently there was some confusion among legislators about the information given to policyholders in our letter.

To set the record straight, I have included a copy of that letter. To avoid any future misunderstanding, I am also including a sample of a follow-up letter to our policyholders.

If you have any questions, please call me. I can be reached at 317-297-4123.

Sincerely,



Lee Tooman
Government Relations

LT/ch

Enclosures

Golden Rule Insurance Company

Home Office
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439
Telephone (618) 943-8000

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

Golden Rule

NEW HAMPSHIRE SAMPLE
123 ELM STREET
ANY CITY NH 03014

April 20, 1994

RE: 000000001

Dear Insured:

Several weeks ago I wrote to tell you about an expensive health insurance law the New Hampshire legislature is considering.

The bill is Senate Bill 711 (SB 711). It includes guarantee issue and modified community rating.

In my last letter, I explained that the combination of guarantee issue and community rating will cause dramatic increases in premiums for most people, particularly the young.

Several customers called and wanted to know what their actual increase would be. I thought you might want to know too, so I asked our actuaries to estimate your premium increase.

The current premium for your coverage is:	$OLDPREM	MODE
Final premium if SB 711 passes:	$NEWPREM	MODE

Your final premium represents the cost of SB 711 when the legislation is fully implemented. It does not include estimates for increased costs due to inflation and medical costs. (This increase is after the phase-in period has been completed.)

As you know, young people generally have lower incomes; older people have higher incomes. Nonetheless, if SB 711 passes, young people will pay extra to lower the cost for

(See reverse side)

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
(317) 297-4149

PLT417

Golden Rule

NEW HAMPSHIRE SAMPLE
123 ELM STREET
ANY CITY NH 03054

April 1, 1994

RE: 000000001

Dear Policyholder:

A proposed law currently being considered by the New Hampshire Legislature will, if passed, dramatically increase your health insurance costs.

The bill number is Senate Bill 711 (SB 711). This bill will:

- require Guaranteed Issue; and
- require modified Community Rating.

"Guaranteed issue" means that people like you, who had the forethought to purchase health insurance in case they got sick, will no longer get the benefit of a lower premium. People who wait to buy health insurance until they get sick will be subsidized by people like you.

"Community rating" means essentially that everyone will pay about the same amount for their health insurance. SB 711 allows small adjustments for such things as age and family status.

Unfortunately, the combination of community rating and guaranteed issue will cause a dramatic increase in premiums, particularly for younger people. Because you will be forced to subsidize others, this legislation is really a tax.

Young people generally have lower incomes; older people have higher incomes. Nonetheless, the young people in New Hampshire will pay extra to lower the cost for older people.

(see reverse side)

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
(317) 297-4149

PLT415

Princeton professor David F. Bradford and American Enterprise Institute research assistant Derrick A. Max recently wrote an article entitled "Soak-the-Young Economics of Clinton's Health Care Plan." The following excerpts are from that article.

> "... community rating in the manner proposed would cause yet another major transfer of wealth away from younger and future generations toward older and wealthier generations.
>
> "... the Clinton plan would dramatically lower the cost of health care insurance for older citizens and raise the cost for younger citizens. It would, therefore, have exactly the sort of worsening effect on the economic circumstances of the young and future generations that leads us to worry about the budget deficit.
>
> "... The Clinton plan for community rating with no age adjustment would impose a negative net subsidy, that is, a tax of about $650 per year on the young person and would provide a positive net subsidy, that is, a grant, to the retiree of $2,000 per year.
>
> "... These figures imply that the Clinton plan would result in a roughly $26 billion increase in annual tax burdens on those aged twenty-five to thirty-four and a $33 billion cut in annual burdens on those aged fifty-five to sixty-four. Because the coverage would be mandatory, there would be no escaping this tax. Could Congress conceivably enact such a program of redistribution if it were considered explicitly?"

Golden Rule

ERIC E KEEFE
523 WINNACUNNET RD
HAMPTON NH 03842-2771

April 25, 1994

RE: 053711283

Dear Insured:

Several weeks ago I wrote to tell you about an expensive health insurance law the New Hampshire legislature is considering.

The bill is Senate Bill 711 (SB 711). It includes guarantee issue and modified community rating.

In my last letter, I explained that the combination of guarantee issue and community rating will cause dramatic increases in premiums for most people, particularly the young.

Several customers called and wanted to know what their actual increase would be. I thought you might want to know too, so I asked our actuaries to estimate your premium increase.

The current premium for your coverage is:	$64.47	monthly
Final premium if SB 711 passes:	$129.61	monthly

Your final premium represents the cost of SB 711 when the legislation is fully implemented. It does not include estimates for increased costs due to inflation and medical costs. (This increase is after the phase-in period has been completed.)

As you know, young people generally have lower incomes; older people have higher incomes. Nonetheless, if SB 711 passes, young people will pay extra to lower the cost for

(See reverse side)

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
(317) 297-4149

PLT4

Mr. DINGELL. Thank you, Senator Shaheen.

The Chair should advise that this committee intends to pursue this matter with more than a little vigor, and we will probably be consulting with you and with Mr. Curiale, Mr. Foley, and Mr. Van Cooper and a number of others about these matters.

Ms. SHAHEEN. I would be happy to help in any way.

Mr. DINGELL. Your comments have greatly piqued our interest in the lobbying efforts that have gone on on this. We have a number of document requests out to Golden Rule and we will probably expand modestly those document requests and will probably be consulting with you as to perhaps other matters that might be of interest to us in these things.

I think we can work together very well in these matters.

Ms. SHAHEEN. I am sure we can.

Mr. DINGELL. The Chair is going to recognize the gentleman from Oregon, Mr. Wyden, for questions.

Mr. WYDEN. Thank you very much.

I want to thank all our witnesses. You have given very troubling testimony about one insurance company that you have, in effect, indicated in your view is at the head of the brigade when it comes to cherry-picking and exploiting the consumer. And I think what concerns me so much is that if one insurer is allowed to engage in these kinds of practices, particularly cherry-picking low-risk consumers, it seems to me, at some point the other insurers have to engage in these same kinds of practices in effect to protect themselves, and then we will have the actuarial death spiral that Mr. Foley described.

Do you share that view, Mr. Foley?

Mr. FOLEY. Yes, that is exactly right. In fact, we have been trying to pass legislation and regulation in Florida. I have been with the department for 2½ years, and the entire time I have been with the department, we have been trying to correct this.

Almost all the companies agree off the record that the death spiral technique does not work, that it is not serving the general interests in the public, or, as a matter of fact, their particular interests. But they also testify to the same thing you just said, as long as there is one company doing it, then in order for us to protect our flank, we have to keep doing it. And so that is why we try to get laws and regulations in Florida to stop everyone from doing it.

Mr. WYDEN. Let us postulate again around that theory for a moment, that if one company is allowed to engage in these questionable practices, others are going to feel they have got to defend themselves.

And I would like to maybe direct this question to you, Mr. Van Cooper; if the insurance industry has to operate under community rating and also accept other insurance reforms, wouldn't this then place all the competitors on an equal footing, on a level playing field, and we would have a system in which these folks would have to compete on the basis of the various merits of their policy but not by trying to get an unfair advantage. Is that correct?

Mr. VAN COOPER. I believe that is correct. And Vermont's experience demonstrates that point. In fact, we do have a level playing field and we do have a very competitive market.

One of the things we noticed was that with the departure of the cherry-pickers, we saw much more capital infused into the State to develop new relationships with providers, to invest more in Vermont as companies didn't have to worry about being selected against by an aggressive underwriter.

Mr. WYDEN. Is it fair to say, given what we have just asked about, then, that the questionable companies, and let us again take your testimony about Golden Rule as an example, are not really victims of the market but in effect they are making the market which is causing the problems for the American people?

Mr. Van Cooper.

Mr. VAN COOPER. Again, I believe that is correct. One of the things that was ironic is we had a bitter fight with Golden Rule and with HIAA during the legislative session in Vermont, is that if you were to talk to the traditional large carriers across the country, in the 1960's and the 1970's, they did community rate. Community rating isn't a novel concept of the 1990's, it is what much of the industry did through the 1960's and 1970's and early 1980's, until the aggressive underwriters began to distort the market and force them to take a more defensive posture.

Mr. WYDEN. Let me, Mr. Chairman, with your permission, I would like to introduce into the record a letter from the Citizen Action Group to the Golden Rule President, Mr. J. Patrick Rooney, and ask a couple of questions with regard to this as well.

Mr. DINGELL. Without objection, so ordered.

[The information follows:]

Citizen Action

1730 Rhode Island Ave., N.W., Suite 403A
Washington, D.C. 20036
(202) 775-1580
(202) 296-40[illegible] (FAX)

Press Release

For Immediate Release:
Tuesday, June 28, 1994

For further information
Contact: Ed Rothschild
(202) 775-1580

Group Calls On Golden Rule Insurance To Come Clean
Asks Company Chairman to Provide Consumers With Record of Application Denials, Claims Denials & Rate Hikes

Washington: In a letter sent to day to the Golden Rule Insurance Company, Citizen Action, the nation's largest consumer organization, called on J. Patrick Rooney, the company's controversial Chairman, to disclose to the public the company's record with regard to denial rates for applications and claims as well as a premium increases, policy cancellation and other vital consumer information.

"The purpose of this letter," wrote Edwin S. Rothschild, Citizen Action Public Affairs Director, is to draw your attention to a serious discrepancy with respect to the type and amount of information you require from and provide to potential Golden Rule health insurance policy holders."

Citizen Action pointed out, referring to a Golden Rule insurance application in the State of Ohio, that the company requires applicants to provide a detailed 10-year medical history, with the name of every doctor consulted within the most recent 5-year period and whether an individual "has had any indication, symptoms, diagnosis or treatment of any disease or disorder" for a whole range of conditions including such common ones as pregnancy, back pain, asthma and sinus problems.

"Golden Rule's application also requires authorization to obtain both medical and non-medical information from anyone with such information. In other words, before it will sell someone a health insurance policy, Golden Rule wants to know almost everything about a potential policyholder," said Rothschild.

"But detailed historical information only flows one way," Rothschild continued. "The company provides precious little information about its treatment of its policyholders. While it proudly touts

its financial rating, it provides no information on all of the following: denial rates for applications, denial rates for claims, its administrative costs, record of premium increases, record of policy cancellation, marketing costs, utilization review protocols, grievance procedures, salaries and benefits of company executives and length of waits to obtain appointments with Golden Rule PPO providers," said Rothschild.

"We believe that if consumers and potential policyholders had this kind of information from Golden Rule and other insurance companies, consumers would be better informed and could make informed decisions with regard to their choice of health insurer," Rothschild added.

"We know from court records and state insurance commissions that Golden Rule has a history of denying legitimate claims, submitting huge premium rate increases, and paying lobbyists to oppose legitimate state regulation," said Rothschild. "And this is a company that uses medical underwriting to screen out individuals who pay pose some risk to the company and utilization review to limit legitimate medical care, yet does not provide the information needed to determine whether Golden Rule itself is a reasonable risk," said Rothschild.

Citizen Action

1730 Rhode Island Ave., N.W., Suite 403A
Washington, D.C. 20036
(202) 775-1580
(202) 296-4054 (FAX)

June 27, 1994

Mr. John Patrick Rooney
Chairman
Golden Rule Insurance Co.
712 11th Street
Lawrenceville, IL 62439-2395

Dear Mr. Rooney:

The purpose of this letter is to draw your attention to a serious discrepancy with respect to the type and amount of information you require from and provide to potential Golden Rule health insurance policyholders. Based on our review of your pre-application form for insurance in the State of Ohio, it is clear that you are seeking a great deal of information from potential customers of your health insurance plans. For example, you request information on an individual's medical history covering the most recent 10-year period. You ask whether an individual "has had any indication, symptoms, diagnosis or treatment of any disease or disorder" for a whole range of conditions including such common ones as pregnancy, back pain, asthma and sinus problems. You also require potential policyholders to provide you with the name of every doctor consulted within the most recent 5-year period.

Furthermore, anyone seeking individual or small group coverage must not only provide answers to all your questions on their 10-year medical history, but also is required to authorize the company, its reinsurers and its representatives

> ...to obtain information that they need to underwrite or verify [my] application for life or health insurance. Any person having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions of me or my family and *any nonmedical information* (emphasis added) about me or my family is authorized to give it to any of the above parties. This includes information related to substance use or abuse. The persons that are authorized to give this information include any doctor or other practitioner of the healing arts, hospital clinic, other health or health related facility, pharmacy, the Veterans Adminsitration, employer, Medical Information Bureau, or insurance company that may have such information.

In short, for individuals seeking to obtain basic health coverage, Golden Rule requires applicants to provide the most personal private medical and non-medical information. Once this information is obtained, Golden Rule can use it to deny coverage to individuals, increase premiums, co-payments and deductibles, deny claims, and cancel policies. In addition, you will continue to have access to such personal, private information, even if you refuse to insure an individual or a small group.

Mr J Patrick Rooney
June 28, 1994
Page 2

Although Golden Rule obtains detailed information on potential policyholders, it provides very little information to potential policyholders when they apply for health insurance coverage. For example, although you tell a consumer the company's A.M. Best rating to indicate its financial strength, a consumer reviewing your application materials to determine whether to apply as a policyholder is unable to learn the following pieces of critical information:

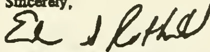
- denial rates for applications
- denial rates for claims
- administrative costs
- record of premium increases
- record of policy cancellation
- marketing costs
- utilization review protocols -- where is utilization review is performed, who does it, what are their qualifications, how are determinations of medical necessity/ appropriateness made
- grievance procedures
- salaries and benefits of company executives
- length of waits to obtain appointments with Golden Rule PPO providers

Furthermore, while Golden Rule reports on the number of employees it has, it does not report precisely how many are employed to do underwriting, what they are paid and how much Golden Rule actually spends to deny people coverage. The public does not know how quickly and completely Golden Rule pays its claims. The public does not know the ownership structure of the company or the extent to which you, as chief executive officer, engage legions of lawyers and other professionals to prevent state insurance regulators from limiting premium increases. The public does not know how much you spend on lobbyists at the state and national level to obtain favorable treatment or to prevent passage of pro-consumer legislation.

Because Golden Rule is primarily engaged in cherry-picking, that is, only insuring those who least need insurance -- the young and the relatively healthy and uses medical underwriting to weed out persons whose medical histories or personal behaviors or livelihood may pose too great a financial risk to the company, you ought to inform prospective policyholders with information relevant to them, especially since they will be spending thousands of dollars a year for insurance.

As the leading provider of individual insurance policies in the nation, we believe that Golden Rule Insurance Company needs to provide a wide array of information to the very people it seeks to become its policyholders. We hope that in the interest of educating health insurance consumers, you will provide us with the information we have requested so that we can make it available to consumers throughout the country.

Sincerely,



Edwin S. Rothschild
Public Affairs Director

Mr. WYDEN. I would like to ask you about a couple of Golden Rule practices that are highlighted in this important Citizen Action inquiry.

The Citizen Action letter points out that Golden Rule not only requires potential policyholders to answer questions about their 10-year medical history, but the company also requires consumers to stipulate that Golden Rule can contact any person having information about "any nonmedical information." This strikes me as just an all-purpose fishing mission by which the company could in effect use just about any possible rationale to deny coverage to prospective consumers.

What do you think about that kind of practice?

Mr. VAN COOPER. One of the problems we had in Vermont was that Golden Rule was both aggressive from the standpoint of initial applications, in which the scope of the questions were very broad, but also as you looked through the claims experience, that they were one of the more aggressive post-claim underwriters, and that is the practice in which once a claim has been submitted, the insurer goes back to the application, reunderwrites to see if there is any basis in which they can state or contend that the insured misrepresented, made a material misrepresentation on the application and use that as a basis for denying coverage. So I would agree. Golden Rule is very aggressive, both from the standpoint of the initial application, only insuring younger and healthier individuals, and getting as much information as possible. But also once they had an insured with significant claims, they again very carefully checked to see if there was any basis on which they could deny coverage.

Mr. CURIALE. I would submit, Mr. Wyden, the proof, as Mr. Foley pointed out, is in the bottom line. When you have a health insurer that has a loss ratio of in the low 40's, you know they are doing something right for their stockholders and something very wrong for their policyholders.

Mr. WYDEN. Let me perhaps ask this question of you, Mr. Foley. Do you feel that Golden Rule is in effect engaging in what amounts to a "bait-and-switch" kind of operation where they lure consumers into the company with initial low premium rates and then systematically proceed to just pound them with rate hikes?

Mr. FOLEY. Mr. Wyden, as I described in my testimony, I am not sure that I would use that phrase. But it appears to me that that is exactly the technique, by insuring only healthy people and those who, as all panel members have pointed out, even those who are remotely having anything unhealthy about them, they exclude that. And then because of the nature of minimum loss ratios and how that affects the premium, we end up with healthy lives leaving the block of business within a couple of years and premiums escalating dramatically, as witness—the 45 percent average rate increase in the last 4 years for Golden Rule.

Mr. WYDEN. Mr. Chairman, my time has expired. But I think it is very appropriate that this committee pursue the same kind of information that Citizen Action is trying to obtain, particularly to try to get a more accurate picture of what this company is about. Because as we saw in the Medigap market, if these kinds of practices are allowed to continue unchecked, they will poison the insurance

sector across the board because they will drive the market and we will see other companies engaging in the same sort of things. So I look forward to pursuing this with you and hope we can obtain much of the same kind of information through your requests in the days ahead.

And yield back.

Mr. DINGELL. The time of the gentleman has expired.

The Chair recognizes the gentleman from Ohio, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

I would like to follow up with some other questions about Golden Rule, follow up with Mr. Wyden's comments.

Mr. Van Cooper, based on your knowledge of insurance and of Golden Rule, we are interested in your assessment of the assertions made by Golden Rule in a letter sent to this subcommittee in April, dated April 19, 1994. This letter was a response to a request from the subcommittee of 26 major insurance companies.

In this letter, Golden Rule refers to a term called "cherry-picking" where they state "traditionally the term cherry-picking refers to the practice of terminating a broad group of insureds and then selectively soliciting the healthy risks to purchase replacement coverage with your company."

Does this jibe with your understanding of the term "cherry-picking?"

Mr. VAN COOPER. No, sir, it does not. I think what you just described was a method by which a company may cherry-pick, but cherry-picking is simply the process or the process by which a commercial carrier selects young and healthy risks in a given marketplace.

I think what you just described is one method that an insurer may use to clean its own book of business. So, for example, if you had an older population, as we just discussed, you can either cancel that book, or an insurer might offer, create a new block of business and reunderwrite that book, the older book, offering the younger people in that population to enter the new book of business, which would, of course, be low premiums, while then in turn, just leaving the older, sicker population in the older book, which in turn sees this extraordinary rate increase, so——

Mr. BROWN. So technically they are correct in that they don't terminate a broad group of people that they are insuring and then selectively solicit the healthy risks, but they do aggressively evaluate which policyholders constitute the greatest risk to them, to the company, and then steer their coverage toward the good risks and away from the bad risks?

Mr. VAN COOPER. Well, I think in Vermont I can't document for you what types of underwriting practices they used with regard to rating books of business, and I know other States may have more detailed experience with that, but that is a method insurers do use to essentially, as Mr. Foley described, segregate out the older, sicker in their insured book of business, put them into a separate pool, which then becomes very, very aggressively rated.

And then, as Mr. Curiale described, at that point, the rates become so great that typically the older and sicker population will go to the insurer of last resort, which I believe in most States is the

Blue Cross and Blue Shield plan, which is what we saw in Vermont, in many instances.

Mr. CURIALE. Mr. Brown, if I can point out, and I think this is an opportunity for me to make a point about cherry-picking, as I made before about cherry-picking and cherry-catching, it doesn't matter one way or another. The problem that we have in this country is not so much insurance companies aggressively seeking younger, healthier people. They don't have to do that.

All they have to do is sit back and if they are allowed. If you have two competing methodologies side by side, as we had in New York State, one methodology or one class of companies that have to take everybody or voluntarily do take everybody and average their rates, which means that their rates are going to be higher for the younger and healthier people side by side with commercial carriers that are permitted to take only those who they think are not going to cost them money and permitted to rate them at a low rate while they are cheap to them, while they are not having health care claims, then it is just common sense that those people who are with the not-for-profit carrier, if they can qualify for what seems to be a great product, they will migrate.

You know, those "cherries" will move. If I am in Empire Blue Cross-Blue Shield and my premiums are supporting people who were sicker than I am, you know, and I can get with Golden Rule, although they are not licensed in New York State or some other commercial carrier, I am going to go, and I am not going to think about the fact that this might not be permanent because that is not advertised.

Those two systems side by side can't exist, because what it means, is your State will be split right down the middle. You will have on the one hand, older, sicker people who are insured for higher rates with the not-for-profits, and on the other hand, younger, healthier people who are insured temporarily with commercials, who are collecting lower premiums but keeping most of it for profits—OK—when those premiums should be subsidizing the older, sicker people, because you are going to be like that sooner or later, but instead they are going for profits. That is the problem.

It is not—it doesn't matter that a company goes out aggressively, sends its agents out and says we are going to strip this company, Empire Blue Cross-Blue Shield, of all its healthy people. It doesn't happen that way.

What happens is those people with Empire say, holy cow, I am paying $9,000 a year for my health insurance. I can go to Chubb or Guardian and pay this. Let me go.

Well, I can only go if I don't have previous health care problems, if I am not in a dangerous occupation, if I am not too old, if I am not an older woman or perhaps a younger woman who might be pregnant, et cetera, you know. Sure, I can go if I qualify, but if I don't qualify, I am stuck; OK? So what happens is you have the "stuckees" and the Golden Rules that are putting that gold, as the Senator said, right into the pockets of their shareholders.

Mr. VAN COOPER. Congressman, if I could just add, in Vermont we experienced a more active cherry-picking process, and I think it became very highlighted. In Vermont, we passed small group reform first. That was in 1991.

Almost immediately upon passing small group reform, we saw some carriers in the individual market begin trying to market products to the group market, small group market, individual products to the small group market. So what we were seeing is that groups were being split up, where an employer would be told here are five very inexpensive individual products, and your one sick employee, well, they will have to get along on their own, or maybe you can put them with Blue Cross-Blue Shield. So you do have this kind of cherry-picking process which can occur very actively.

We began to see it in our small group market, which is one reason why it was urgent to pass nongroup reform, the individual market reform that we did in 1992.

Ms. SHAHEEN. Congressman Brown, if I could just add something to that. The other ultimate outcome of what has been talked about and what Superintendent Curiale talked about and what was part of the driving force for the reform in New Hampshire, is that if we force all of the people who are sick, who are not young and healthy to go with Blue Cross-Blue Shield or some other nonprofit, then the ultimate outcome of that is that those companies have financial difficulties and either can no longer insure the people who are very ill or they get into financial trouble and are threatened with going under.

So it seems to me that is another very important reason why we have got to make community rating work everywhere, because if we don't, we are going to have those people who are providing the coverage now for the sick people, no longer are going to be able to do that.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. DINGELL. The time of the gentleman has expired.

The Chair recognizes the gentlewoman from Pennsylvania.

Ms. MARGOLIES-MEZVINSKY. Thank you, Mr. Chairman.

Citizen Action, which is, as you may well know, the country's largest consumer organization, called upon Golden Rule to, and I quote, "disclose to the public the company's record with regard to denial rates for applications and claims as well as premium increases, policy cancellation and other vital consumer information."

Based on all of your statements, it seems as if you would wholeheartedly agree with Citizen Action's request and, in fact, would most likely share some of the concerns about the accuracy of information Golden Rule already is supplying to potential policyholders, and those already insured. Would you agree with that?

Mr. VAN COOPER. Absolutely, but I would also note, one of the things that we were very—we were the first State to pass community rating legislation, and rather than get into a battle of data or a battle of information, we really relied on common sense, and getting back to what the purpose of insurance is, community rating and guaranteed acceptance makes sense. There is no reason why carriers cannot make a fair profit in that type of market. And it is clearly beneficial to Vermonters, and I think it would be beneficial to the country. So I think that it is helpful to get information.

But I would urge a movement nationally towards community rating and guaranteed acceptance that makes sense. They stand on their own two feet, these concepts. And probably the best, the telling truth of just how good these reforms are, is that prior to these

reforms, many of the calls, many of the complaints that the department would get were from consumers who were unable to find coverage, who were being priced out of the market or who truly had heart-wrenching stories where they had a newborn child for whom they could not get coverage, for whom they didn't know how they were going to take care of their medical needs, who would ask us—how can an insurer be permitted to do this?

I get none of those calls today. So I think I agree, information data is needed, but the data won't tell as to whether this should be done or not. I think just on principle it makes good sense and it is sound business.

Ms. MARGOLIES-MEZVINSKY. What about on the other end, do you get calls from people who feel that they are unnecessarily bearing the burdens of older and less healthy people?

Mr. VAN COOPER. Certainly, in Vermont when we initially passed the reform proposals, we got calls from consumers concerned that they were seeing their prices going up, but again my experience repeatedly was that when you explain to a Vermonter what these reforms were about, that it was about the cross-subsidization within a pool of insurers, that it was about taking care of their neighbor, that it was about providing stability in the marketplace so that when they themselves became old or sick, they would be able to have this product when they needed it the most, uniformly people accepted it and were willing to put up with the slight increase to have a stable, rational marketplace.

Mr. CURIALE. Congresswoman, I would like to echo that. That was our experience in New York, too. There was a great outcry, particularly as the Senator here said, before the law actually became effective. And I think that hearings such as these, and certainly information we have put out before this, have convinced a great many people that indeed they were getting very low prices for something that was worthless. And that, yes, the percentage increase is very high, but they are still paying reasonable prices that they can afford for a product that is now valuable and that will be there when they need it. That is what the most important thing is, and I think people are beginning to understand that.

Ms. MARGOLIES-MEZVINSKY. So the assumption is that initially when the change goes from experiential to community rating, that there will be some hue and cry, there will be concern from people because the rates will go up, but if it is properly presented to them and the understanding is there, that somehow levels off?

Mr. CURIALE. Yes, especially if people were to read the transcript of this hearing, for example, about how you get an initial low rate but then ultimately you are systematically raised until those of you who are in the group who are healthy are offered a new product at a low rate, but those of you who are not are stuck and will get double and triple rates and ultimately be priced out of coverage.

People who realize that this is what is happening and what has been happening, they will then accept the fact that maybe they should be paying a little bit more for a product that is valuable, for health insurance that is going to be there when they need it.

Ms. MARGOLIES-MEZVINSKY. I would actually like to meet some of these people who read the transcripts of these hearings.

Mr. VAN COOPER. I think you have identified an important issue, however, which is that if your market has been skewed through years of underwriting, where you have tremendous differences between the highest and the lowest premium, there is an issue as to transitioning into a purely community-rated population.

So, for example, in Vermont, we do have the deviations from the community rate of plus or minus 20 percent, the small group market and plus or minus 40 percent currently of the individual market, until 1995 when it will be ratcheted down to 20. And the whole purpose of those deviations was to allow us to slowly move towards a purely community-rated market, so as to avoid a rate shock, so as to avoid the shock to a younger, healthier population and potentially have them withdraw from the market. That was our concern when we were the first State to go forward.

In retrospect, I don't think it was necessary to have the deviations. So, in fact, we were being cautious, and we were partly responding to the tremendous amount of negative feedback that we received from both the Health Insurance Association of America and the industry in general.

Mr. FOLEY. The thing I wanted to point out is it is very difficult for people to understand when they are healthy that they are at some point going to become unhealthy. My wife and I are both middle aged and we were in tremendous health until 2 years ago when she discovered she had breast cancer, and that gives you a whole new perspective on life, and I tell people that. And the other thing that we need to keep in mind is that to a very great extent because of cost shifting, we are paying for those costs now.

Ms. MARGOLIES-MEZVINSKY. Anyway.

Mr. FOLEY. That is exactly right, but because 80 percent of the people in this country are covered with group health insurance, most of whom don't pay their premium, they don't know the costs that we are incurring and they don't know the cost of cost shifting.

Mr. CURIALE. That is what I was going to point out. We in New York bit the bullet and we went to pure community rating to the extent that we did not permit age rating, and there was a hue and cry about that. But, in effect, most of the people that are younger even, are insured through their employers, and most employers have a mix of people, younger and older, and so it was not those people who really felt it.

It was certainly those smaller number of people who do pay directly their health insurance premiums who were 25 who feel they are invulnerable, the invulnerability of youth and who may have indeed jumped out of the system. And certainly universal coverage would prevent that and it should be pursued.

The other thing I would point out is that younger people have a remedy also. They can buy policies with higher deductibles that will reduce their premiums, they can go into HMO's, because HMO's are more attractive to younger people who are not attached to their physicians or do not have serious medical conditions for which they feel a certain physician is life and death to them. So there are other adjustments that can be made and are being made.

Ms. MARGOLIES-MEZVINSKY. Mr. Chairman, do I have time for one more question?

Mr. DINGELL. Certainly.

Ms. MARGOLIES-MEZVINSKY. I see the red light on.

I would like to go back to the Citizen Action press release and letter. The letter draws out what I believe to be an important dichotomy in Golden Rule's practices. Our second panel here today is going to address these issues in more detail, but I would like to ask you a question with regard to what is being said here.

Citizen Action suggests that—and once again I am quoting "the purpose of this letter is to draw your attention to a serious discrepancy with respect to the type and amount of information you require from and provide to potential Golden Rule health insurance policyholders." Now the emphasis that I am presenting here to you is my own.

The letter points out that "Golden Rule requires a highly detailed 10-year medical history from each applicant, but that the detailed historical information only flows one way."

What have been your States' experiences with the type of information that Golden Rule disseminates to its prospective policyholders?

Specifically, do you believe that it gives consumers the information that they need to make informed choices?

Mr. FOLEY. Let me talk about that just a minute.

Our bureau receives consumer complaints about rate increases. I have absolutely no evidence to indicate that Golden Rule has informed prospective policyholders that in the last 4 years their average rate increase in Florida has been 45 percent, because we get many, many calls from consumers saying, why did my premium go up, why did my premium go up. So it seems to me at the very minimum, that if they are going to be disclosing to policyholders this kind of rating practice, they should at least show the rate increase history.

Ms. MARGOLIES-MEZVINSKY. Is that a fine print problem?

Mr. FOLEY. I am not sure what you mean by a "fine print problem."

Ms. MARGOLIES-MEZVINSKY. It was somewhere there in the fine print, and they just didn't read it?

Mr. FOLEY. No, no, that is not a fine print problem at all. It is not there at all, it is not disclosed.

Mr. VAN COOPER. I guess I would just add that the better way to remedy this problem is if you have community rating and guaranteed acceptance, you don't need all those questions because the consumer has guaranteed access to the marketplace, and if you are in that type of an environment, you don't need disclosures from the insurer as to what future rates will be because rates are going to be set fairly and equitably across a broad population. So I think with these reforms in Vermont, it is very simple to get health insurance, you just walk in and if you pay your premium, you will be insured.

Ms. MARGOLIES-MEZVINSKY. Thank you very much.

Thank you, Mr. Chairman.

Mr. DINGELL. Ladies and gentlemen of the panel, the Chair advises that those two lights you see up there indicates there is a vote on the Floor. The Chair would suggest that we should probably recess for about 20 minutes while we go over and vote.

Would that be inconvenient? Because I do have some questions the Chair would like to direct to the panel. Your testimony has been most helpful, and as you have been testifying, I have been not only listening but following your statements and looking at some of the comments about Golden Rule which are most interesting.

We know that they are going to enjoy their appearance here and we are going to enjoy their appearance here, and I am sure, Senator, you will enjoy their appearance here.

Ms. SHAHEEN. If only I could be here.

Mr. DINGELL. The committee will then stand in recess for 20 minutes. We will return here then at, let's say, 10 after.

[Brief recess.]

Mr. DINGELL. Ladies and gentlemen of the panel, the Chair apologizes to you. Instead of one vote, we had three. So I have done you a discourtesy, but I want you to know it was not intentional. The Chair has a few questions.

Senator, this question to you if you please: Of every dollar paid in premiums by policyholders to them, Golden Rule kept about 46 cents. Can you describe this as a high, medium or low profit margin?

Ms. SHAHEEN. I think in New Hampshire we would certainly describe it as a high profit margin. And as we discussed earlier, I think that in fact one of the problems that we have with health insurance in this country is with commercial carriers like Golden Rule who aren't putting the money into health care, they are putting it into their own pockets.

Mr. DINGELL. Mr. Curiale, you have a comment?

Mr. CURIALE. Yes, that is an unconscionably high profit margin.

Mr. DINGELL. Why do you say that? You are an insurance regulator. You deal with hundreds or perhaps thousands of insurance companies.

Why would you make that statement?

Mr. CURIALE. Well, in health insurance in New York, we like to see a for-profit health insurer have something like a 70 percent profit margin—excuse me, 70 percent loss ratio, and we would expect a not-for-profit carrier to have something like a 90 percent loss ratio. As a matter of fact, in New York we have a situation where if you are writing individual insurance and you have lower than a 55 percent loss ratio, we will either make you increase your benefits or lower your premium. And so something that is in the neighborhood of 45 percent is just absolutely unacceptable.

Mr. DINGELL. What would be about the highest rate you would find amongst insurance companies in New York?

Mr. CURIALE. It is hard to know, because as I said, under the old law we weren't approving the rates of the commercial carriers but we were looking at them, and we have seen companies that are in loss ratios in the 60's, which we consider to be low. That is a low loss ratio in New York, I believe, in the 60's. But down to 55, we would not bring them in. At 55 or lower, we would bring them in and make them adjust their rates or increase their benefits.

Mr. DINGELL. Mr. Foley, do you have a comment?

Mr. FOLEY. With regard to the level of loss ratios, one of the main problems is with smaller policies, as I pointed out in my written testimony. Now, Golden Rule is not specifically in this market,

at least in Florida, but the smaller the policy and the smaller the premium, then the larger the fixed costs are as a percent of that premium, and so then we may get loss ratios in the low 50's or even the high 40's.

It is our strong belief that what we need to do is expand the kind of policies so that people are covered under one policy so they don't need to buy supplemental policies and have these loss ratios.

Mr. DINGELL. Mr. Curiale referred to this as being unconscionably high. Do you have any views on whether it is unconscionably or not unconscionably high?

Mr. FOLEY. In Florida Golden Rule's loss ratio experience generally is in the mid-60's.

Mr. DINGELL. In the mid-60's?

Mr. FOLEY. That is right.

Mr. DINGELL. Why is it that in Senator Shaheen's State it is as high as it is and in your State it is as low as it is? What is the reason for the difference?

Mr. FOLEY. Well, again the loss ratio in Florida is like 65 percent, so they are returning 65 cents on the dollar. Now, if I understood your question to her and what is going on in New Hampshire the loss ratio there is 46 percent, is that right, so they are only returning 46 cents on the dollar? OK.

I really don't have any explanation other than we have very vigorous regulatory activity in Florida that may account for the fact that they are returning a higher portion of the premium in Florida.

Mr. DINGELL. You permit them to do business in Florida, they are in the Senator's State.

Mr. Van Cooper, are they doing business in your place?

Mr. VAN COOPER. No, Golden Rule withdrew from the State of Vermont as a result of Vermont's community rating and guaranteed acceptance requirements. In fact, I would agree 46 percent is an extremely low loss ratio. Vermont's individual law, reform law requires a loss ratio of 70 percent; in the small group market our average loss ratio is about 85 percent and in the nongroup market it is even higher than that.

Mr. DINGELL. Now, Mr. Curiale, why aren't they doing business in New York?

Mr. CURIALE. I couldn't answer that, Mr. Chairman.

Mr. DINGELL. Bad business climate?

Mr. CURIALE. Probably so. One of the things, we don't permit, for example, "dread disease" insurance. They have cancer policies which have a very low loss ratio. We also, on Medicare supplement, we have a minimum loss ratio of 75 percent. And as I say, once you get to around 55 percent, we begin to interfere with the company in terms of what benefits they are giving and what they are charging. So it could very well be that they don't want to do business in New York because of those reasons.

Mr. DINGELL. Now, Senator Shaheen, as you indicated, Golden Rule vigorously opposed health insurance reform in your State. I think we ought to take a little look at the tactics that they have employed in their pursuit, their opposition to health care reform.

In your statement, you referred to a letter you received from an attorney representing Golden Rule. In the letter the author, one Edgar R. Lantis, dated April 27 of this year, threatens legal action

against you by stating the following about comments you had made about Golden Rule: "These statements are false, malicious and defamatory and as such represent libel per quad, if not libel per se. Similar future comments if made out of the protective cocoon of the legislative chambers may be actionable and appropriate for consideration by a court of competent jurisdiction." Is that correct?

Ms. SHAHEEN. It is certainly correct that those were his allegations.

Mr. DINGELL. Those were his allegations.

Now, have you ever made, to your knowledge, any false, malicious or defamatory statements against Golden Rule or have you merely told the truth?

Ms. SHAHEEN. I believe that I have told the truth and in fact I think that is what they objected to, that they were misrepresenting what was in the legislation, and deliberately doing it in an effort to kill the legislation.

Mr. DINGELL. Now, it is a long time since I practiced law, so I am a little rusty on this business, you understand, but the language seemed to be rather strong. As a matter of fact, if I were going to send a letter like that, I would expect somebody to say, "Dingell, you were attempting to bully and intimidate me by sending that kind of letter." Would that be a fair statement?

Ms. SHAHEEN. I think that is absolutely fair. There was no question in my mind that that was an attempt to intimidate me, and I think the fact that they copied it to the local reporter in my area was further evidence of that.

Mr. DINGELL. I sense your presence here indicates you are not intimidated?

Ms. SHAHEEN. No, and as I indicated, actually that tactic backfired on them because the fact that we then—that I then released his letter and people found out that that is what they were trying to do, I think there was a real resentment about it.

Mr. DINGELL. Now, Senator, did you think that the letter seemed to be designed to have a chilling effect on you and to curb your attempts at free expression about items and issues of critical importance? Did you have the feeling that it might be an attempt to send a message that others who were tempted to do the same might face a similar letter or perhaps a similar response from Golden Rule?

Ms. SHAHEEN. There was no question about that, that they were trying to, particularly given the timing of it, that it was shortly before the vote in the House, that there was a real effort to make other legislators aware that they would stop at no lengths to intimidate us.

Mr. DINGELL. This letter seems to indicate that your participation in this hearing today and your statements about what might serve the public interest might be grounds for legal action by Golden Rule against you, is that correct?

Ms. SHAHEEN. I assume that I could interpret it that way; that is correct.

Mr. DINGELL. Well, we would like to know about it if you get any more letters like this from them.

Ms. SHAHEEN. I will certainly forward them to you.

Mr. DINGELL. Now, Senator, tell me, is such action of a very aggressive character by Golden Rule in which they seem to threaten

a public official, whether State legislator or any other government official, a common practice for insurance companies or any other company?

Ms. SHAHEEN. Well, it certainly wasn't a common practice as far as I was concerned. I had never had that kind of a threat made against me since I have been in political life, which has been some time, and I am not aware of any other company in New Hampshire that I have seen do business with the legislature that has made those kinds of threats.

Mr. DINGELL. Is it fair to observe that Golden Rule goes after public officials such as State insurance commissioners with personal lawsuits against them?

Ms. SHAHEEN. I was surprised after the threat against me, and we began to do a little investigation, that this is not—this is apparently not an uncommon tactic for Golden Rule.

Mr. DINGELL. Mr. Curiale, Mr. Foley, Mr. Van Cooper, have you heard of any instances of this kind by Golden Rule?

Mr. CURIALE. I have not.

Mr. DINGELL. Mr. Foley?

Mr. FOLEY. There is litigation ongoing in Florida against the insurance commissioner by this company. It occurred before I started with the department. I don't have any details.

Mr. DINGELL. Does it involve personal action by Golden Rule against the commissioner?

Mr. FOLEY. That is my understanding, Mr. Chairman.

Mr. DINGELL. Do you know anything about this?

Mr. FOLEY. No, I don't have any details. They purposely kept me out of it because it happened before I got to the department.

Mr. DINGELL. I don't want you to testify about that which you know nothing. I want you to be entirely correct and comfortable in your testimony here.

Mr. Van Cooper, what can you tell us about these kind of things?

Mr. VAN COOPER. Nothing of that nature has occurred in Vermont. I believe there are other States which are involved in litigation with Golden Rule.

Mr. DINGELL. Thank you.

The Chair is going to recognize my good friend from Colorado, Mr. Schaefer.

Mr. SCHAEFER. Thank you, Mr. Chairman.

Senator, I would like to follow up on the Chairman's question. He was talking about the April 27 letter. They also sent a letter out to all of their policyholders of insurance on April 25, which utilize scare tactics to the individual. It indicated that their premium at the time was "X" dollars, and if Senate Bill 711 passes, it is going to vault up tremendously. Have you seen any such effects now that this legislation has been passed into law?

Ms. SHAHEEN. It actually doesn't take effect until January 1, 1995, so we don't have any information about what the impact will be on rates. But I think the information that we were able to gather about the letters that they sent out to their policyholders, they used a flat 170 percent increase, which I assumed they were basing on their guess about what had happened in New York, and they used that for all policyholders across the board. So as I understand while the increase in New York has applied to only a small per-

centage of the market, what Golden Rule said to all of their policyholders is that your premium will go up 170 percent, regardless of what age you are and any other problems.

Mr. SCHAEFER. Approximately, how many policyholders do they have in the State of New Hampshire?

Ms. SHAHEEN. About 5,600, a little over that.

Mr. SCHAEFER. Was there a reaction by other Members of the House or the Senate to this type of thing? In other words, did people start calling in saying, hey, we have a problem here?

Ms. SHAHEEN. They did. In fact, there was a very dramatic reaction. We probably had hundreds of phone calls from people, and it was one of the things that almost submarined the legislation because other legislators got very nervous about that response because it was a very technical bill, very difficult to understand.

Mr. SCHAEFER. Well, I applaud you wholeheartedly for continuing on and pushing it through. It takes a lot of guts.

Ms. SHAHEEN. Thank you.

Mr. SCHAEFER. As a matter of fact, the State of Colorado had a somewhat similar situation, and even though they didn't, at least to my knowledge, send out letters to this effect or threaten the sponsor, they did gut the bill in the Colorado House of Representatives. Then it went over to the Senate where Senator Bill Schroeder, whom I know very well, got it back in proper form. In that case, I think their holders were only about 1.4 percent of the total market. Now, we see somewhat of a pattern developing here, whether it is a lawsuit or letters of threats on whatever.

Any comments at all on what I am saying? There is a pattern out there I guess is what the Chairman and this committee is saying. This is not just happening to you or a few others.

From the testimony that I have heard today, it would appear that Golden Rule's action represented a rather extreme example of practices that are unfair to insurance consumers, and we have talked about some of this up to this point. But do you see any relative similarities in other insurance companies that had done anything similar to this or does this one really stand out like a sore thumb?

Anyone, please.

Mr. CURIALE. Just, Golden Rule is not licensed in New York. They appear to be the leader in terms of the most aggressive practices that we all feel are not in the interest of policyholders and not in the interest of the general public good. But again, I think it has been pointed out how we all feel, I think, about what needs to be done, and that is that the system needs to be changed so that you cannot have a susceptibility for insurers to do the kinds of things that Golden Rule has done.

If you have a system of guaranteed issue and community rating, then all of this goes away because they just cannot get away with these kinds of things. If they want to be in this market, if they want to do health insurance, if they want to do health care financing, as I like to put it, then they have got to take everyone and they have got to average rate, they have got to play by the rules, they have got to spread the risk, they have got to take their share of healthy people and sick people.

Mr. SCHAEFER. Anyone else?

Mr. VAN COOPER. Congressman Schaefer, if I could just echo the commissioner's comments. I think one of the great virtues of Vermont and what attracted us to community rating or requiring guaranteed acceptance is that these are market-based reform proposals and they are extremely simple.

You do not get into the convoluted contortions of risk pools, you don't get into the stigma of putting your consumers into uninsurable risk groups. There are market-based solutions.

You simply change the rules of the market to reflect how they operated, in many instances, in the 1960's and 1970's, and then allow insurers to compete on the quality of the service they provide, on their ability to control costs. And we have found that it has been very successful, again just changing the rules and allowing the insurers to compete fairly.

Ms. SHAHEEN. If I could add to that, the other issue for us in New Hampshire in trying to respond to what Golden Rule was doing, we filed complaints both with the insurance commissioner and with the attorney general on their lobbying activities and on the way they were handling the insurance market. And both responses from the attorney general and from the commissioner of insurance was that according to the laws in New Hampshire, there was no way to address their abuses within the system as it is now, which is why I think we really need to change the system. I would echo what has been said on the panel.

Mr. SCHAEFER. Well, Senator, you and the members of this panel certainly understand lobbying. There is a proper way it is conducted and an improper way. Here, we have seen, as far as I am concerned, an improper way.

As a matter of fact, this particular Member faced a very similar situation about 4 years ago with the telephone company that came out rather harshly against a piece of legislation that I and four other sponsors proposed. We stood up to them, and we haven't seen the same thing occur again. So, hopefully, some of this is going to take a back seat.

Let me ask any of you, the gentlemen or the Senator, do you see any reflection on this and the potential possible passage of health care reform back here. Do you see any correlation?

Anyone.

Mr. VAN COOPER. If I may, I think community ratings or a requirement of guaranteed acceptance are essential first steps, but they are limited in their scope. But these market insurance reforms require insurers to guarantee access, so any consumer has the right to be insured by any of these insurers, but it doesn't address the ability of the consumer to purchase that coverage. So I think in Vermont, at least, clearly the next step is to move towards universal access.

We spent much of this last legislative session trying to push through a bill that would achieve that, and it failed. I expect we will be back next year because these reforms, while they guarantee access, they don't necessarily assure the consumer that he or she can purchase the coverage.

Mr. SCHAEFER. Please.

Mr. CURIALE. I would also say that New York would welcome universal coverage, we would welcome a fair, equitable and financ-

ing mechanism. We know that is what all of you all are struggling with right now. I think we need that.

We, as I said at the beginning of my comments, I don't like to be put in the position of saying that New York's insurance reforms are effective and working, when, in fact, others are using that essentially to defeat efforts to do universal coverage. They use it in a way saying, well, we don't need universal coverage because Curiale in New York is saying that these work.

Well, they do work, but they would work perfectly if there were universal coverage because there would be no leakage, you would have a sealed system that everyone was in from birth to death, everyone was paying into the bank account that ultimately they could draw on later in their lives. That is the way it should be.

Mr. SCHAEFER. I have just one final question.

Mr. DINGELL. The gentleman continues to be recognized.

Mr. SCHAEFER. How are we to tell when a company's so-called "post-claims underwriting" goes a bit, what we might say, over the line? Is it part of the job of the insurer's claim department to root out the fraud and misrepresentation and to deny coverage when it is found?

What has Golden Rule done that other companies don't or that you could care to comment on?

Mr. CURIALE. They are not licensed in New York. Again, most of the time we would find out through our consumer services department. We get complaints about health care claims all the time.

In fact, it used to be that most of our claims were on auto insurance, and everything else divided up the rest of the percentage. Now it is about 40 percent auto insurance, 45 percent health care claims, and 15 percent the rest.

Yeah, that is what we find, we find out about them through complaints. What we do is we try to use leverage to get things settled. If there is a question of fact, a company will rely on that, we do not determine questions of fact. It has to be clearly a violation of a policy before we can get in there and make a company do something.

But we get so many complaints on health care nowadays in terms of payments of claims, whether a procedure is experimental or not experimental, this is a gut-wrenching question that I think the country has got to deal with: What price hope, what we are going to pay for, what we are not going to pay for, is a 5 percent chance at life which costs $150,000 the type of thing that we will pay for?

Can you criticize a company one day for having rates that are too high and then another day criticize them for denying a bone marrow transplant?

Mr. SCHAEFER. I think most policyholders, at least that I know of, if they have a claim and they get their paperwork in the mail from the insurers saying, well, we are paying this, this, this and this, or it is a bill from the doctor saying the insurance company paid all this, but you still owe this, most people aren't going to complain unless it is a humongous amount of money. They have no way of really knowing or understanding whether they are getting the proper receipts or not. I think this is something that we have to grapple with.

Mr. CURIALE. Absolutely.

Mr. VAN COOPER. Congressman Schaefer, just to respond as to Vermont's experience, again I think the issue is to change the system so you don't have post-claim underwriting. For example, in Vermont today, because it is a guaranteed issue environment, we no longer have any post-claim underwriting issues in these marketplaces. They simply cease to exist because you are not being underwritten initially through an application.

And I certainly think one of the problems we saw over the years was that post-claim underwriting typically occurs where you have a significant claim, and in many instances, the consumer isn't as sophisticated perhaps as the claims adjuster about conditions.

I will give you an example that I actually handled years ago, which was a very old Vermonter who had purchased a product, I believe this was—it wasn't comprehensive major medical, but a long-term care product.

She put down she had Parkinson's disease. She needed to have nursing home coverage. She entered the nursing home, and the coverage was denied, post-claim underwriting.

Why? Because she had some other disease that she hadn't listed on the application.

Well, after months and months, and we had to have testimony, written statements from various medical experts, it turns out that the disease that the company was citing as a material misrepresentation was a commonly associated disease with Parkinson's. And that is the type of difficulty that the consumer has. And I think it is very difficult for States, State insurance departments to be as helpful as they might be because so often they are fact-intensive, whether or not something is a material misrepresentation is a very, very fact-intensive determination.

Mr. SCHAEFER. Well, Senator?

Ms. SHAHEEN. Thank you.

If the foundation of our health care system were to insure health care for everyone as opposed to the current system of let's see how we can limit the risk for so many carriers and deny people health care coverage, then we wouldn't be addressing those kinds of problems. So I would add my voice to other members of the panel in encouraging a plan that has universal coverage for everyone.

Mr. CURIALE. I think New York's reforms as well as Vermont's reforms did away with exclusions. Health insurers can no longer exclude a preexisting condition. And so as Tom has just mentioned, if you change the law, you change the system, you don't have these problems to deal with.

Mr. SCHAEFER. Well, in conclusion, I would just like to thank the panel. I, with the Chairman, would apologize for all the votes we had and keeping you here so long.

But I would yield back my time, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman.

I would like to ask you one more question, if you please. You may answer that in any way you feel is appropriate.

What are the practical effects of insurance companies requesting one, two or even three rate hikes in 1 year?

Now, I believe Golden Rule does this. Is this an example of what is common throughout the industry?

What are the ordinary practices and what are the practical effects of this?

Senator, do you want to start addressing it first?

Ms. SHAHEEN. Sure. I think the—I have not seen that other carriers have made a practice of asking for those kinds of rate hikes in New Hampshire, and the practical impact of that is for people to drop their insurance coverage because they can't pay those kind of rate hikes.

Mr. DINGELL. Mr. Curiale, what would your comments be?

Mr. CURIALE. I think what that is, is an obvious attempt at churning. They will raise their rates, then reunderwrite those that they believe to be healthy and young enough on new policies and the others will be stuck with the ever-increasing costs that are associated with those pools, and eventually they will lose them. They will keep their body of policyholders that they can make a whole lot of money on and get rid of everybody else.

Mr. DINGELL. You are defining this as being a step which is directed less at adjusting rates than essentially adjusting the ratepayer base and identifying those that they want to keep, getting rid of those who are bad risks, keeping those who are good risks, and essentially using this as a device to increase their profits. Is that what you are telling me now?

Mr. CURIALE. Absolutely. That is the name of the game, Mr. Chairman. The name of the game is having young, healthy policyholders and getting rid of everybody else.

Mr. DINGELL. Now, you have already defined the policies of the New York Commission. You obviously responded to this in some fashion.

What is the way in which you addressed this?

Mr. CURIALE. The way we addressed it is to say that you have got to have open enrollment and community rating, you have got to have average rating so that every policyholder you attract in there is going to pay the average rate, and you can't do this any longer. You won't be able to attract younger and healthier people by promising them low rates because they are going to pay the average rate, and therefore it takes away the whole incentive to do the kind of conduct that you have been talking about.

Mr. DINGELL. Thank you, Mr. Curiale.

Mr. Foley.

Mr. FOLEY. I would like to reinforce what was just said. Again in Florida, as I presented earlier, we feel very strongly that you need to have standardized benefits and standardized premium format, guarantee issue and community rating so that you can do premium comparisons, provide real marketplace competition between and among insurers.

I think about the situation as a regulator, I am tremendously concerned about inadequate initial rates, because I know that if a company charges initial rates that are inadequate, then at some point consumers are going to be subjected to the kind of rate increases that they will find not sustainable, so they will leave the block of business and we end up with the death spirals.

On the other hand, if we have guaranteed issue and community rating and standardization, the initial premiums might be a little bit higher, but as a regulator, I don't need to be concerned about

what that level of premium is, because if company A wants to escalate premiums, now all the insurer has to do is walk down the street and on a guarantee issue basis get coverage from company B, C, D or E, so they are no longer going to be stuck in death spirals.

Mr. DINGELL. So you are seeing competition at play as a result of that device?

Mr. FOLEY. That is exactly right. To reinforce what has been said, a lapse rate is the percentage of people in force under a policy form that leave during a given year. Once we get in the height of death spirals, and Golden Rule—I am looking at four sets of numbers right here—half the people leave each year. So if you start out with 10,000 policies in force, by the time you start the next year, there are only 5,000 in force. By the time you start the next year, there are 2,500, so in 3 or 4 years, those people are all gone, they are weeded out, and they have gone elsewhere. That doesn't work. That is not what we are in business for.

Mr. CURIALE. And Golden Rule take some of those policyholders under new contracts, but they will only take the ones that are healthy, so what they do is they get the best of both worlds. They get to reunderwrite every few years, and they will take you if you qualify again, but they want to take another look at you, and those who don't qualify again, they are out of luck.

Mr. DINGELL. And unless you have a requirement of this sort that Mr. Foley has been describing, you may not be able to get new insurance policies because of preexisting conditions, bad health or something of that sort?

Mr. CURIALE. Absolutely, Mr. Chairman.

What you want is you want insurers to compete not on the basis of who can attract and keep the youngest healthiest policyholders, but on the basis of who can give the best as much as who can manage health care the best, who can satisfy the customer and who can compete on price in terms of cost control the best.

One of the byproducts of this is that cost control is forgotten about by companies like Golden Rule because they don't need to control cost. They don't pay any claims. All they need is to control their body of insureds and they do that very well.

When you have a group of insurance companies that are open enrolling, taking everybody, and community rating, boy, they have a major incentive to control those costs because that is the only way they are going to be able to compete. If they can pick and choose young and healthy people only, they don't have to worry about costs.

Mr. DINGELL. Mr. Van Cooper.

Mr. VAN COOPER. I would just echo the comments of the panel. In Vermont one of the things that precipitated our form was rate instability, where groups or individuals would be experience rated, and they would have the ironic result when you needed the coverage the most, you could afford it the least.

What we have seen now with community rating is tremendous stability in the market. Rates in Vermont are guaranteed for 12 months. We also have common benefit plans so consumers can shop, they have wide choices of products, they have a common ben-

efit plan so they can make an apples-to-apples comparison amongst the companies.

It is a much more competitive market and a much easier market for the consumer. And it is particularly, I think important to focus on preexisting conditions. In Vermont, if a Vermonter has had coverage for 9 months prior to an application, there is no preexisting condition period. So there is complete portability, you can shop across the market, you can go from one insurer to another, and I think that encourages competition within the marketplace, as well as keeping rates down.

Mr. DINGELL. Thank you.

Are there any further comments from the panel?

The Chair wants to express my thanks to you all. You have been most helpful to us and we are very appreciative.

Mr. Curiale, we are glad to see you back. We appreciate the good work you are doing up there in New York, and thank you all for being here.

Thank all the members of the panel.

The Chair announces the next panel is composed of Mr. Stephen J. Hough, of Croegaert, Clark & Hough Ltd., 305 East Main Street, Olney, Illinois, and Ms. Kathryn Kristine Groenke, 1532 Marlborough Road, Crofton, Maryland.

Mr. Hough, Ms. Groenke, we thank you for being with us this afternoon. If you come forward we will discuss the rules and practices of the committee.

Mr. Hough, Ms. Groenke, do you have any objection to testifying under oath?

The Chair advises that it is the practice of the committee and has been so since its earliest days. The Chair also advises that you are each entitled to be advised by counsel if you so choose during your appearance here because you will be testifying under oath.

And the question then is do you desire to be advised by counsel during your appearance?

Mr. HOUGH. No, Mr. Chairman.

Mr. DINGELL. The other matter of discussion is that copies of the Rules of the House, Rules of the Committee, Rules of the Subcommittee are there to inform you of the limitations on the power of the subcommittee as you appear here before us.

The last thing I want to do is to express my personal apologies for the inconvenience occasioned by the number of votes which took place on the Floor which prevented me from being with you so that you could be completing your business in a more timely fashion.

If you then have no objection, would you please each rise and raise your right hand.

[Witnesses sworn].

Mr. DINGELL. You may each consider yourselves under oath.

We will recognize you first Mr. Hough, then you, Ms. Groenke.

TESTIMONY OF STEPHEN J. HOUGH, CROEGAERT, CLARK & HOUGH; AND KATHRYN KRISTINE GROENKE, CROFTON, MD

Mr. HOUGH. Thank you, Mr. Chairman and Members of the subcommittee and distinguished guests.

My name is Stephen J. Hough, I am a partner in the law firm of Croegaert, Clark & Hough, Ltd, in Olney, Illinois. I have been a partner with that firm since 1988.

Our firm is one of the largest firms in southeastern Illinois. That is not to say that we are a large firm, but there aren't just a whole lot of large firms there, most are sole practitioners and one or two lawyers.

I would like to state to the committee that I am here on my own volition, I am not here on behalf of any specific client, I am not here on behalf of my firm, I am here because I was asked to be here by the subcommittee, and I have no axes to grind against Golden Rule, which will probably be news to them.

In the winter of 1985, my firm, specifically a Patrick McLaughlin was contacted by an attorney in Rock Falls, Illinois, with regard to a case involving Golden Rule insurance which had been filed in Lawrence County, Illinois. Lawrence County, the county seat there is Lawrenceville, Illinois, it is 20 miles from my hometown. It is the alleged home office of Golden Rule insurance.

A claim had been filed under a miscellaneous remedy, charging that two people, Mr. and Mrs. Fletcher, had made material misstatements of medical ailments when applying for their insurance coverage in September 1984. The case was filed in Lawrence County, which is 320 miles away from Dixon, Illinois, which was where the people resided, and about 350 miles or 360 miles away from Rock Falls, Illinois, where the insurance agent/broker practiced.

All things pointed to the fact that this case should have been brought in Lee County, Illinois. Instead, it was filed in Lawrence County; all of the physicians, the policy of insurance was delivered in Lee County, the physicians medical records, results of medical tests were located there, the defendants were located in Lee County, Illinois, and the broker who lived and signed the application for insurance lived in Rockford, which is in Winnebago County, which is about 40 miles away.

The only alleged, and I keep stressing the word "alleged" connection with Lawrence County, Illinois, was the fact that that was Golden Rule's home office, and that was where the policy was "allegedly" accepted and "allegedly" issued. We argued the case—we filed a motion forum non conveniens intrastate.

At the time this case came in, the State of Illinois had not yet enacted Supreme Court Rule 187, which allowed for interstate transfer of cases. We had interstate transfer based upon cases filed in the State of Illinois, particularly Madison and St. Clair County, which could be transferred back to Missouri if there was a defendant there or to establish venue.

We took some time in getting this case rolling because Rule 187 had been proposed, there had been—it had not been enacted yet and we got the defense firm to agree to it.

When finally our motion was heard, the court in Lawrence County ruled that venue was proper in Lawrence County specifically because that was the last act of the contract, the issuance of the insurance policy. We thought that there were no relevant portions of that transaction that occurred in Lawrence County. This occurred in April 1988.

In November 1988, the same court, same judge ruled the venue was improper in Lawrence County and transferred the case to Lake County, Illinois. This case involved a Russian immigrant named Maria Manasherov. Mrs. Manasherov had applied for insurance with Golden Rule in January 1987 and paid a premium. The policy was issued effective July 12.

One of her children went to the hospital on January 8. Golden Rule denied the claims, filed a suit in Lawrence County, Illinois. Mrs. Manasherov and her family had never heard of Lawrence County, they hadn't been here all that long.

The local counsel was hired by a firm in Buffalo Grove, Illinois. The local counsel in that case was Jerry Doyle Miller who had formerly been a partner in the firm that I am now a partner in and just works a block down the street.

He had heard about my case, asked me to help him with the whole forum interstate non conveniens action because it was relatively new. I agreed to give him all my research and tell him what happened to my case.

The case was transferred back to Lake County, Illinois, which is where it belonged. Again, all the doctors lived there, the application for insurance was signed there, Mrs. Manasherov wrote her check there. Anything that would possibly be connected with this case indicated it should go to Lake County.

An appeal was filed in the Fifth Judicial Circuit of the State of Illinois, Mount Vernon, Illinois. The decision was affirmed. By this time Golden Rule had hired new counsel, Mr. Guy McGaughey, Junior.

Mr. McGaughey filed a petition for rehearing which was very short on the understanding of the law but was arguing impassionately for Golden Rule's denial of its "constitutional right of due process in its home county, thus giving it an implied invitation to move from Illinois at the risk of losing 300 to 400 jobs in a depressed southern Illinois economic area?"

At this time, southern Illinois was very, very economically depressed. We had arguments between cities and counties and towns arguing for prisons. We couldn't get any industry to locate there.

Golden Rule is the largest industry in Lawrence County, Illinois. Their office is directly cross the street from the Courthouse in Lawrence County, Illinois. You can imagine how someone is going to feel when they have been sued by Golden Rule to pull up to the courthouse and this is an old time small town, you park on the street and you get out of your car and look across the street, Golden Rule Insurance Company. You could imagine that people aren't going to think they are going to get a fair trial.

Mr. Miller advised me of Ms. Manasherov's affirmative decision and I attempted to get my case reheard. The Circuit Court there correctly denied that.

By this time, I had been getting calls from other attorneys, particularly the State of Tennessee and the State of Illinois wanting us to represent them with cases that clients had been sued by Golden Rule for alleged misstatement of fact and not telling them about preexisting conditions.

At approximately the same time, I noticed in the American Trial Lawyer Bulletin, two or three different lawyers looking for information with the vexatious refusal to pay by Golden Rule.

One of the attorneys was in Alaska. I cannot recall his name and I have since lost that file. I believe it has been sent back to the State of Tennessee, and that note got out of there.

I also spoke with Mr. Kevin Hannon who is an attorney in Colorado. Mr. Hannon forwarded to me a document he had received from the Colorado Bureau of Insurance which was a letter from an actuarial service in North Carolina.

I had previously provided this to the committee and would ask that it be attached to the statement, if it has not already been done so.

I spoke to an attorney in Alaska, which based on the time difference between Illinois and Alaska, was pretty difficult to do. He advised me that somehow or another he had gotten discovery in his case and got some computer files from Golden Rule.

The letters in there were very discourteous to policyholders, accusing them of being fraudulent and dishonest and seeking policy benefits that were due them. I discussed this matter with all the attorneys who had represented and referred cases to me, and I went to Lawrenceville, Illinois, on my own.

I started with 1975 to just see how many cases Golden Rule Insurance Company had filed. In 1975, they filed none; in 1976, they filed none; in 1977 and 1978, there were no cases filed; in 1979, they were a defendant in a case; in 1982, one miscellaneous remedy case was filed; in 1983, there were 9; in 1984, there were 23; in 1985, there were 28; in 1986, 15 or so; 14 in 1987, and then it started to get really interesting. In 1988, 1989, and 1990, the numbers were 22, 23, and 41 respectively; in 1991, 38 cases.

Members of the subcommittee, Lawrence County, Illinois, is a very small county. They don't have a very large court docket. I have taken the liberty to go over there within the last couple weeks and pull the court dockets from 1987 forward for the miscellaneous remedy dockets. More than half of the cases involved on the miscellaneous remedy dockets were filed by Golden Rule Insurance Company against policyholders.

Almost every one of those cases were for misstatements, material misstatements of fact on the application or nondisclosure of a preexisting condition.

I shared my information with several attorneys in Tennessee, my friend Jim Guill, at McConnell & Boyd. And his successors at that firm, other attorneys, would call me from throughout the country wanting to file a class action suit against Golden Rule. Quite frankly, we didn't have the money to do it.

I spoke with several lawyers in Illinois, Herschel Tomilson, a very well-respected attorney in Urbana, Illinois, Jerry Doyle Miller, Morris Lane Harvey, other attorneys, Terry Cade, who had the same situations, the exact same pleadings were filed in every case. It always involved a case that after the application for insurance was filed, the policy was issued, a claim was made within a relatively short time, Golden Rule would post-underwrite and deny.

I have provided for the committee, the subcommittee pleadings that have been filed in just one case. This document I am holding

in front of me, if you can see the size of it, is the complaint. Attached to that complaint are the policy for insurance, the application, and letters to my client, Mr. Stuart G. Ossen of Memphis, Tennessee.

Mr. DINGELL. Without objection, the committee will receive the list of cases which you have referred to earlier and they will be inserted in the record.

The Chair will also receive the pleadings to which you referred and we will have them reviewed and see whether we can fit them at the proper level of expense into the record of this proceeding. Without objection that will be so ordered.

Mr. HOUGH. Mr. Dingell, I also have from another case the discovery which was filed in the case, and this case is still pending in Lawrence County. This was filed on one day.

Mr. DINGELL. I think that would be useful. Without objection the same unanimous consent request is in order.

Mr. HOUGH. Thank you.

The pleadings in these cases were nothing more than attempts to intimidate policyholders. As I indicated to you, there were over 100 cases filed before 1990. Most of the cases I was involved with were 1987, 1988, 1989, and 1990 cases.

Just for matter of record, in 1994 we are now exactly, almost exactly ½ of the way through the year, there has been one claim filed by Golden Rule in Lawrence County, Illinois. I would like to think that that is because there were a few brave people who took them on and got the cases transferred out to where they belong.

Unfortunately, I believe it is because Golden Rule has now done other things that doesn't necessitate them filing those claims.

A person who would receive the summons and the documents I showed you of the complaint and all the attachments was easily intimidated. They had paid a lot of money for an insurance premium. They also, every one of them, had filed a claim which was denied. They were looking at several thousand dollars in insurance costs that were not covered which they thought were covered.

The last thing in the world they want to do is hire a lawyer to defend a case in a place they have never heard of, and they most certainly do not want to hire someone such as myself or other attorneys in the area whom they have never heard of, never spoken with, don't have anything good to know about us.

Fortunately, there were a few of these people who went to attorneys, and these attorneys were able to root out someone in the area that would handle the case.

I did not get wealthy defending these cases. I charged $300 to $400 as an initial retainer. It is ½ hour drive from my office to the courthouse in Lawrence County, ½ hour drive back. I would file a petition to change venue and go argue it.

Unfortunately, I have been to the appellate court more than once on these Golden Rule cases. The very first case, the one I told you about in 1985, our client paid us over $1,300. He paid deposition costs of almost a thousand dollars, and he paid an attorney in Rock Island, Illinois, to fight a claim.

I went through the pleadings this morning. That lady and gentleman paid a total of $1,075.31 in claims. Their check was refunded—or excuse me in premiums. Their insurance policy was re-

jected for nervousness, high blood pressure, and irregular heartbeat.

The lady in that case had pains in her jaw that radiated into her chest. She was being honest with her doctor, telling her that is where the pains went. Those medical records were used to deny her claim.

In January of that year, these people were sent a letter stating that you made material misstatements of fact to us regarding preexisting conditions, you have 15 days to accept this rider. Otherwise, we are not going to cover you. They didn't respond. Golden Rule filed suit.

Another gentleman that I represented applied for an insurance policy. The insurance policy is attached, Members of the subcommittee, to the pleadings, and there are questions on there that indicate if you have had nervousness, any kind of problems. He was denied, one of the reasons being he had recurring night sweats and low-grade fever.

They indicated to him that he made material misstatements, hid preexisting conditions. Another factor was he had incontinence of bowels. We have all had that. He had been impotent since an automobile accident in 1987. That was specifically put on the policy. He put that on there, pain in upper ear, pain in the ear and upper body since 1988, chronic bronchitis and aleolectosis and bronchiosis, cynobractas syndrome. He had never heard of that until he got the complaint from Golden Rule.

I spoke this morning with one of my former clients in Tennessee who I was able to get the case transferred back to Memphis where it belonged. He took out a policy with Golden Rule which was effective on March 2, 1990, for illness effective March 16 for 1990, for accidents.

He put on there that he had cystitis in 1994, no recurrence. His wife had had one abnormal pap smear 7 years before. The policy for insurance was taken out. The last seven tests were normal.

On May 31, 1990, just a couple of months after the policy went into effect, he was admitted to the hospital with pulmonary histoplasmosis, discharged June 11, 1990. You can imagine what his medical bills were. The claim was denied.

The gentleman was in the real estate business, he had no insurance, he—I spoke with him today. We got his case transferred, and it was dismissed in Tennessee. He got no justice there, either.

Fortunately for him, I was able to get that one moved. I didn't have to fight very hard because after the first few fights we had "Golden Rule Day" in Lawrence County. The attorney who began representing Golden Rule in about 1987 or 1988, would file these pleadings, get them set, people would have 30 days to answer, and then they would start sending in all the discovery requests, which I showed you.

We would get them set, get them set for a motion for a change for venue, I would leave my office, prepare for the case, go to Lawrenceville, walk in to argue the case, no attorney. Usually 5 or 6 minutes before the hearing was to be set, a circuit clerk would run in or a secretary for Mr. McGaughey's office, which is on the other side of the square, would come in and say: Mr. McGaughey is unavoidably detained in such and such a place on Golden Rule

business, he can't be here today. Mr. McGaughey was a sole practitioner.

Most of the time, members of the subcommittee, I didn't charge my client for that. How could I? I would drive back and it would take weeks and months to get a case set.

If I was successful in getting a setting, the judge would be taken off because he was prejudiced against Mr. McGaughey or prejudiced against Golden Rule. The only prejudice was that judge ruled against Golden Rule and wouldn't let the case stay in Lawrence County, Illinois. Even after the Manasherov case went to the Appellate Court, every time they got beat and transferred, there was either the threat or an appeal to the Illinois Appellate Court. That is very expensive. It doesn't take long for that kind of thing to get around, and people will not fight.

I found out later that most people would call the Circuit Clerk's Office in Lawrence County, Illinois, just to find out, A, where Lawrenceville was, and B, if they could find an attorney, and they were told that Golden Rule wins almost every one of these cases. So the 100-some cases that were filed, and the very few that I represented, less than a dozen, and the very few that I know of which are probably another dozen or two more, I would say the great majority of these people just gave up. Those are the cases that were filed.

Before the cases were filed, letters were sent to them saying you have 15 days to accept this rider or your coverage is terminated. I would suggest to the subcommittee, and I have no proof, that most people either gave up or accepted the rider. Those letters and things are attached to the pleadings that I provided for the subcommittee.

One of the cases I handled—I did three at a time because as I told you, we had "Golden Rule Day," either Mr. McGaughey or counsel from Indianapolis would come in and we would just do them all one day before a judge that they would accept.

We had a typographical error, instead of having Cook County on there we had Lake County. We ended up going back to the Appellate Court and being reversed on that on a typographical error. They fought that. I made the suggestion at that time that, hey, this is a typographical error, just change it. No.

After reading the letter that my friend Mr. Hannon provided to me, I have no doubt that the legal actions by Golden Rule and their attorneys are nothing more than an attempt to deny claims.

I have never, ever, in the cases I have represented, people who have been sued by Golden Rule, seen a reason given by a physician as why a claim was denied, but often saw an employee of Golden Rule under the guise of an underwriter determine on his own that a policyholder suffered from a preexisting condition or that an application for insurance contained material misstatements of facts about prior medical conditions. These conditions often had nothing to do with the medical conditions of the policyholder at the time the claim was made but was an arbitrary denial by a paid employee of Golden Rule.

These practices have resulted in great financial difficulty for some of the denied claimants and the necessity of paying attorneys

fees in the attempt to obtain a fair trial. Based upon what I have heard, these practices enabled Golden Rule to profit greatly.

The way I read it, and the way I read the publicity that was coming out of Lawrenceville, Illinois, and southeastern Illinois in the late 1980's they were on the verge of bankruptcy because of increasing claims and fraud, government regulation. I was shocked to learn what they make.

Finally, on behalf of all the denied claimants throughout the United States and their lawyers, I would thank you for giving us a chance to speak out on this injustice and implore that you don't let this happen again. Let's not let someone make an arbitrary decision which can cause financial ruin to someone who thought they were covered.

Thank you very much.

[The prepared statement and attachments of Mr. Hough follow:]

Statement of Stephen J. Hough to the Subcommittee on Oversight and Investigations

My name is Stephen J. Hough. I am a partner in the law firm of Croegaert, Clark and Hough Ltd. in Olney, Illinois. Our firm is one of the largest in Southeastern Illinois and devotes a substantial amount of our time to personal injury and medical malpractice work, both on the side of plaintiffs and defendants.

In the winter of 1985, our firm was contacted by Mark Merritt, an attorney in Rock Falls, Illinois. Mr. Merritt's clients had been denied coverage because the clients had allegedly misstated various medical ailments when applying for coverage in September 1984. All aspects of the case indicated that if there was a controversy, the cause should have been tried in Lee County, Illinois. The application for insurance was prepared in Lee County; payment of the premium was paid in Lee County; the policy of insurance was delivered in Lee County; all of the physicians, medical records and results of the medical tests were located in Lee County, Illinois. The Defendants, Mr. and Mrs. James Fletcher, were residents of Lee County, Illinois. The agent who assisted the Fletcher's with the application, and the broker who signed the application were residents of Rockford, Winnebago County, Illinois, about 40 miles from Lee County. Nonetheless, the claim by Golden Rule was filed in Lawrence County, the alleged home of Golden Rule Insurance Company. Golden Rule claimed that venue was proper because Lawrence County was the county where a relevant portion of the transaction occurred, and the underwriting of the policy and acceptance of the Fletcher's offer occurred. The Court in Lawrence County ruled that venue was proper in Lawrence County, Illinois, effectively ignoring our forum non conveniens argument on April 19,1988.

On November 21, 1988 the court, in another case with the same Judge presiding, ruled that venue was improper in Lawrence County and transferred the case to Lake County, Illinois. This case involved a Russian immigrant, Maria Manasherov, with very limited command of the English language. Ms. Manasherov had applied for insurance with Golden Rule on January 6, 1987, and on that date paid a premium. Golden Rule issued the policy effective January 12, 1987. One of Ms. Manasherov's children was admitted to the hospital on January 8, 1987. Golden Rule denied the claims and filed a complaint in November 1987. The complaint was filed in Lawrence County, Illinois, even though Ms. Manasherov and her family had never heard of this county, much less been there. The Manasherov family filed a motion to transfer venue in Lawrence County, Illinois. I assisted the local counsel, Jerry Doyle Miller with his argument and research. Mr. Miller was successful in getting venue transferred to Lake County. Golden Rule filed an appeal to the Appellate Court of Illinois, Fifth Judicial Circuit and the decision was affirmed. Mr. McGaughey, the new counsel for Golden Rule, filed a Petition For Rehearing which was short on understanding of the law, but impassioned for Golden Rule's denial of its "constitutional right of due process in its home county, thus giving it an implied invitation to move from Illinois at the risk of losing 300–400 jobs in a depressed Southern Illinois economic area?"

After hearing of the Manasherov decision from Mr. Miller, I attempted to have the Fletcher case reconsidered. This was denied, but I took a second look at the Golden Rule cases. This was partly because of other cases that had been sent to our office from attorneys in Tennessee and other cases in Illinois. I had also read

inquiries in the ATLA bulletin seeking information about Golden Rule and their refusal to pay claims. I called a few of the attorneys in the ATLA bulletin and was surprised to learn that Golden Rule filed similar cases against policy holders from Alaska to Colorado. I spoke with Kevin Hannon, an attorney in Colorado who forwarded me a copy of the letter from the actuarial service in North Carolina which I have previously provided to the Committee. I also spoke to an attorney in Alaska who had somehow received form letters to policy holders from Golden Rule computer files, and found out that these letters were very discourteous to policy holders, accusing them of being fraudulent and dishonest in seeking policy benefits that were due them. After discussing the matter with these attorneys and my clients, and reviewing the letter sent to the Colorado Commissioner of Insurance, I went to Lawrenceville and determined that the filings in Lawrence County were no doubt the master plan of Golden Rule to increase profitability at whatever means necessary. The letter predicted economic disaster for Golden Rule unless certain changes were made, one of which was the preexisting conditions clause being raised from one year to two years. My research showed that more than 20 claims were filed in Lawrence County in 1988, 23 were filed in 1989, 43 were filed in 1990, 40 were filed in 1991 and 8 were filed in 1992.

My research showed that the majority of the pleadings were extremely lengthy, recited numerous passages of the policy and the application, and were always filed against policy holders who made claims a relatively short period of time from the payment of the initial premium. Golden Rule's attorney, Mr. McGaughey would file these long pleadings and sought to have coverage voided. These cases were filed in Lawrence County, where the courthouse is directly across the street from the alleged home office of Golden Rule. For those members and guests of the Subcommittee that are unaware, Lawrence County is a rural area of Southeastern Illinois. It is extremely difficult to fly in to Lawrenceville commercially an the nearest airports are in Evansville, Indiana, Indianapolis and St. Louis. Golden Rule is also the largest employer in Lawrence County, and at the time of these filings, one of the biggest contributors to clubs, civic organizations and schools.

The pleadings filed by Golden Rule and Mr. McGaughey had the tendency to intimidate the policyholders and for the most part persuaded them that the fight was too costly. After all, most of these people were now facing thousands of dollars of medical bills for which they had no coverage, and the thought of hiring an attorney to fight these claims was too much for them to bear. Even those policyholders who consulted an attorney learned that they were going to have to hire counsel from Southeastern Illinois to seek to have venue returned to their home county or home state. This necessitated finding an attorney in their home county and that attorney contacting someone like myself to file a forum non conveniens action. I would ask the lawyer and the policyholder for a nominal retainer, usually $300-$500. I would then file a motion to transfer venue to the county or state that the policyholder resided.

Immediately after our motion for change of venue was filed, my clients would be bombarded with briefs and affidavits opposing the change of venue. These pleadings were dozens of pages long, and often contained pleadings entitled "Request To Admit Facts" which were basically recitations of policy language or application questions and answers. In Illinois, failure to answer these Requests within 28 days means that they are effectively admitted and can be used against you in trial or for purposes of summary judgment. These pleadings would be sent to my office via regular mail, I would have to read them and send to be answered by my client and have them returned to me by mail. If my client had any questions, it would often make it necessary for them to call me at night or on weekends to meet the deadline. Without fail the clients would recognize that this was costing them more money and begin to have doubts about the wisdom of fighting an insurance company. Again, these people also had large medical bills which had been denied coverage by Golden Rule and for the most part the last thing they needed were increased expenditures for legal bills.

After my motions were filed and the sea of paper response filed by Golden Rule, it became increasingly difficult to have the motion heard by the court. Mr. McGaughey was usually the only attorney handling the cases for Golden Rule, and he was a sole practitioner. Even if the cases were scheduled months in advance, Mr. McGaughey would file a motion for continuance citing unavoidable delays in other jurisdictions, often other states. Most of the time these "motions for continuance" were delivered either via phone from a secretary or having a secretary walk across the street to tell the Lawrence County Circuit Clerk. If Mr. McGaughey were available, he would often make a motion to change the judge because of prejudice against Golden Rule or Mr. McGaughey. Often this prejudice consisted of nothing more than the judge having previously ruled to change venue to the appropriate county or

striking a frivolous Golden Rule pleading. Needless to say, after an attorney has prepared for one or more of these hearings only to have it continued, or driven several miles to Lawrence County only to return with no order to move venue out of Lawrence County, he is very reluctant to send a bill to his client. This is especially true when each correspondence and phone call is prefaced with "this is really costing me a lot of money, are you sure we can get this matter moved?"

Eventually, we were successful in getting the cases moved out of Lawrence County. However, Mr. McGaughey on one occasion filed an appeal because of a typographical error on the order and was successful in getting the case moved back to Lawrence County, at the expense of several hundred dollars to the Defendant.

One of the cases I was successful in getting transferred back to Tennessee necessitated getting affidavits from several people in Tennessee and an affidavit from me. These affidavits were necessary to show congestion of the court docket, hardship for witnesses to travel from Memphis, Tennessee to Lawrence County, Illinois and the presence of treating physicians and medical records in Tennessee and other aspects to show why venue was proper in Tennessee. Again, these cost a lot of time and money to obtain. The case was transferred to Memphis and to my knowledge has not been pursued any further by Golden Rule.

I have no doubt that the legal actions by Golden Rule and their attorneys were nothing more than an attempt to deny claims. I never saw any physician give a medical reason why a claim was denied, but often saw an employee of Golden Rule, with no medical background, determine that a policyholder suffered from a "preexisting condition" or that an application for insurance contained material misstatements of facts about prior medical conditions. Often these conditions had nothing to do with the medical conditions of the policyholder at the time the claim was made, but was an arbitrary denial by a paid employee of Golden Rule. These practices have resulted in financial difficulty for the denied claimant and the necessity of paying legal fees to obtain a fair trial. More often than not, the policyholder would not enter an appearance in Lawrence County, choosing instead to have a default entered against them which ended their coverage and made them liable for bills which should have been covered by an insurance policy. When one reviews the circumstances, these practices enabled Golden Rule to profit greatly.

On behalf of denied claimants throughout the United States and their lawyers, I thank you for giving us our chance to speak out on this injustice, and implore you to make sure that it doesn't happen again.

BEST'S
INSURANCE REPORTS
LIFE-HEALTH

1993 Edition

Published Continuously since 1905

The Insurance Information Source

A.M. BEST COMPANY
Oldwick, New Jersey 08858 • (908) 439-2200 • Fax: (908) 439-3363

NEW BUSINESS ISSUED
(in thousands of dollars)

Year	Whole Life & Endow.	Term	Credit	Group	Industrial	Total Insurance Issued	Non Par (%)	Par (%)
1986	27,726	2,691	...	..		30,417	.	100
1987	41,899	591	.	...	.	42,490		100
1988	37,142	64	..	. .		37,206		100
1989	43,214	2,399	..	....		45,613		100
1990	47,352	. 37	....	.	.	50,209	..	100
1991	49,375	3 730	. ..	.	.	52,105	.	100

INSURANCE IN FORCE
(in thousands of dollars)

Year	Whole Life Endow & Adds	Term	Credit	Group	Industrial	Total Insurance in Force
1987	79,569	22,463	...	..	12,979	115,011
1988	109,428	3,701	. .	..	12,624	125,753
1989	112,981	9,385	. .	. .	12,041	134,407
1990	122,035	15,215	...	. ..	11,440	148,690
1991	124,218	21,416	...	..	11,042	164,672
1992	138,399	33,077	..	. . .	10,166	181,643

COMPANY DEVELOPMENT
(in thousands of dollars)

Year	Admitted Assets	Surplus Funds	Condit'l Reserve Funds	Net Premiums Written	Net Invest-Income	Net Gain
1987	19,679	1,394	669	3,564	1,604	-94
1988	20,169	1,404	255	3,711	1,503	-238
1989	20,775	1,367	242	3,756	1,599	11
1990	21,304	1,206	158	3,682	1,648	-277
1991	22,353	1,240	164	4,204	1,692	-150
1992	23,035	1,268	201	4,735	1,600	7

COMPARATIVE FINANCIAL DATA
(in thousands of dollars)

Year	Net Income	Realized Capital Gains	Unrealized Capital Gains	Interest Maintenance Reserve	Stock-holder Dividends	Policy-holder Dividends
1988	-295	-38	12			339
1989	-10	-31	-15			91
1990	-186	92	-29			169
1991	3	155	31			126
1992	25	17	48	.		30

Profitability Tests

Year	Best's Rating	Ben Paid to NPW	Comm & Exp to NPW	NOG to Tot Assets	NOG to Tot Rev (BT)	Return on Equity	NOG to NPW	Change in C&S
1988	B	66.2	76.7	-1.2	-4.6	-17.0	-6.4	0.6
1989	B	65.5	77.5	0.1	-0.6	0.7	0.3	-2.7
1990	B	69.5	84.3	-1.3	5.1	20.3	-7.1	-11.8
1991	B	65.9	78.2	-0.7	2.0	-12.5	-3.5	2.6
1992	B	65.4	72.6	0.0	0.1	0.5	0.1	2.3

Liquidity Tests

Year	Operating Cash Flow($000)	Quick Liquidity	Current Liquidity	Non-Inv Grade Bonds to C&S & AVR	Delnq & Forclsd Mtg to C&S & AVR	Mort & RE to C&S & AVR	Affil Invest to C&S & AVR
1988	664	22.1	101.9	...	1.9	1.5	...
1989	645	4.2	101.5	...	1.3	1.2	.
1990	811	2.6	100.7	30.7	1.3	.	.
1991	710	3.2	99.9	35.0	2.7	...	.
1992	384	11.8	99.2	19.2	..		..
1992 Best's Adjusted Tests		121.1	121.1	..	...		..

Leverage Tests

Year	C&S to Liabilities	Surplus Relief	Gross Leverage	DPW to C&S	NPW to C&S	Change in NPW
1988	5.0	0.1	15.3	2.7	2.8	4.1
1989	8.4	.	13.3	2.8	2.7	1.2
1990	5.8		31.9	3.2	3.2	3.6
1991	5.8	0.0	31.4	3.5	3.4	9.9
1992	6.6		18.5	2.8	3.8	11.5
1992 Best's Adjusted Tests			11.6	2.3	2.2	.

GOLDEN RULE INSURANCE COMPANY

712 Eleventh Street
Lawrenceville, Illinois 62439
Tel.–618-943-8000 Fax: 618-943-8031
AMB Number: 06263 NAIC: 62286

1993 BEST'S RATING

Based on our current opinion of the company's financial condition and operating performance, it is assigned a Best's Rating of A+ (Superior). The company's Financial Size Category is Class VIII. Refer to the Preface for a complete explanation of Best's Rating system and procedure. Rating Effective: July 6, 1993.

RATING RATIONALE

The rating of Golden Rule Insurance Company reflects the company's high quality investment portfolio, its strong profitability, its strong market niche in the health insurance field, and its good capitalization. Partially offsetting these strengths are regulatory risks to the company's health insurance segment and the dividend requirements of the parent company.

Since 1989, the company's core health insurance segment has produced strong earnings and contributed to the strong improvement in Golden Rule's capital ratios. This profitability is attributable to the company's careful underwriting, its sophisticated claims systems, and its adequate rate increases. Although Golden Rule has developed a strong niche position in the individual health insurance market, this segment is exposed to the regulatory pressures facing the health insurance market. This factor, together with potential dividend requirements of the parent company, may result in lower increases to the company's currently strong capital levels.

OPERATING COMMENTS

Invested assets are more fully commented upon under "Investment Data". The return on invested assets as reflected by the net yield before Federal income taxes in 1992 was 6.73%. Overall net investment income provides more than ample margins (188.2%) to cover contractual interest required to maintain policy reserves. Life reserves are computed principally on the Commissioners Reserve Valuation Method with interest primarily at 3%, 4 1/2% and 3 1/2%.

In operations a very important item is expenses, which have been low on the average. Careful selection and underwriting of business has produced a mortality experience which appears reasonable. Policy lapses and surrenders on ordinary business have been very low in recent years.

Activities of Golden Rule Insurance are primarily in the individual and group accident and health field, with generally profitable underwriting results achieved (except in 1987 and 1988). During 1988, a $18.7 million operating loss was reported reflecting adverse claims experience in both the individual and group health lines which contributed to a 32% decline in total surplus funds. The implementation of rate increases, the raising of deductibles and marketing limitations on certain group health coverages has returned operating results to a profitable status during each of the past four years. In four of the past five years, the company has paid stockholder dividends totaling $28 million to its parent organization. Despite the dividends to its parent, the company grew capital and surplus by $98 million in the last four years.

At year end, publicly traded long-term bonds represented over 88% of total invested assets. During the past four years, the company has "turned over" the majority of its bond portfolio.

GOLDEN RULE INSURANCE COMPANY—Continued

ASSETS AND LIABILITIES — December 31, 1992
(In thousands of dollars)

Assets		Liabilities	
*Total bonds	$789,493	+Net policy reserves	[illegible]
*Total preferred stocks	13,410	Policy claims	54,241
*Total common stocks	21,193	Interest maint reserve	6,761
Mortgage loans	57	Comm taxes expenses	21,114
Real estate	6,488	Asset val reserve	0,023
Policy loans	4,460	Other liabilities	17,891
Cash	10,763		
Short-term investments	24,528	Total Liabilities	$755,985
Life & annty prems due	330	Common stock	3,263
Acc & health prems due	6,463	Surplus debentures	1,076
Accrued invest income	13,322	Paid in & contrib surpl	14,162
Other assets	5,535	Unassigned surplus	21,569
Admitted assets	$896,057	Total	$896,057

*Securities are reported on the basis prescribed by the National Association of Insurance Commissioners. +Analysis of reserves: Life, $187,606; annuities $395,121; supplementary contracts with life contingencies, $319; accidental death benefits $32; disability active lives, $187; disability disabled lives, $129; miscellaneous reserves, $187; accident & health, $69,895; supplementary contracts without life contingencies $2,316

SUMMARY OF OPERATIONS (ACCRUAL BASIS)
(In thousands of dollars)

Premiums:		Death benefits	$8,089
Ordinary life	$52,260	Matured endowments	82
Individual annuities	106,604	Annuity benefits	1,930
Group life	5,033	Surrender benefits	33,325
Acc & health group	225,474	Acc & health benefits	361,483
Acc & health other	350,536	Int on policy funds	41
		Supplementary contracts	1,120
Total premiums	$739,904	Incr life reserves	43,342
Supplementary contracts	1,097	Incr a & h reserves	14,299
Net investment income	50,724	Commissions	60,231
Amort interest maint res	875	Insur taxes lic & fees	17,398
Other income	1,978	General ins expenses	89,176
Total	$795,180	Total	$762,624
Gain from operations before FIT & div to policyholders			$32,556
Dividends to policyholders life			413
Gain from operations after dividends to policyholders			$32,143
Federal income taxes incurred			20,000
*Net gain from operations after FIT and dividends			$12,143

*By-line breakdown ($000): Ordinary life, $1,339; individual annuities, $1,247; supplementary contracts, $28; group life, $890; group annuities, $6; acc & health group, $16,784; acc & health other, $12,629

Direct premium writings by line ($000): Ordinary life, $54,100; individual annuities, $106,604; group life, $5,121; accident & health group, $225,474; accident & health other, $350,546; reinsurance ceded, $1,940; net premiums, $739,904.

SUMMARY OF PREMIUM INCOME
(In thousands of dollars)

Year	Direct Premiums Written	Reins Assumed	Ann/Oth Fund Deposits	Gross Premiums Written	Reins Ceded	Net Premiums Written
1988	409,397	315	..	409,712	1,171	408,541
1989	383,524	301	...	383,825	1,466	382,360
1990	460,497	344	.	460,840	1,658	459,183
1991	578,815	157	....	578,972	1,751	577,221
1992	741,844	0	....	741,844	1,940	739,904

DISTRIBUTION OF PREMIUM INCOME
(in thousands of dollars / % of total)

Year	Individual Life	%	Annuity & Fund Deposits	%	Group Life & A & H	%	Credit Life & A & H	%	Other A & H	%
1988	15,711	4	59,708	15	69,873	17	...	.	263,229	64
1989	18,667	5	30,908	8	34,876	9	...	.	297,915	78
1990	39,243	9	28,381	6	34,454	8	...	.	357,306	78
1991	52,244	9	60,345	10	110,529	19	...	.	354,107	61
1992	52,260	7	106,604	14	230,506	31	...	.	350,536	47

CAPITAL SURPLUS ACCOUNT
(In thousands of dollars)

Net operating gain	$32,143	Cash dividend stkhld	$10,000
Net real cap gains	13,394	Loss non-admitted items	436
Fed tax-cap gains	-11,000	Incr asset val res	2,075
Net unreal cap gains	150	Adj prior year taxes	131
Surplus debenture retired	70	Incr cap & surplus fund	22,325
Total	$34,956	Total	$34,956

CASH FLOW ANALYSIS
(In thousands of dollars)

Funds Provided		Funds Applied	
Cash from oper	$793,939	Benefits paid	[illegible]
Long-term bond proceeds	1,374,235	Comm taxes expenses	[illegible]
Other cash provided	82,857	Long-term bonds acquired	[illegible]
Decr cash & short-term	11,943	Other cash applied	[illegible]
Total	$2,262,975	Total	$2,262,975

Life business in force ($000): Non participating, $7,904,868; participating, $3,074; total, $7,907,942. The foregoing includes: Ordinary reinsurance ceded, $888,057; group reinsurance ceded, $15,459. Total reinsurance ceded, $903,516; ordinary additions by dividends, $293; ordinary paid-up insurance, $239,892; total extended term, $6,219. Additional accidental death benefits included in life policies, $89,930.

INVESTMENT DATA
(In thousands of dollars)

Bonds (88% of admitted assets): U S government, $141,225; states, etc. $678; political subdiv of states, etc., $91,232; special revenues, etc. $214,504; public utilities, $22,857; industrial and miscellaneous, $318,991. The bond of one issuer with a par value of $75 (statement value $71) was reported in default.

DISTRIBUTION OF BONDS BY MATURITY

	0-1 Yrs	1-5 Yrs	5-10 Yrs	10-20 Yrs	Over 20 Yrs	Avg Maturity
Government	0%	4%	4%	1%	6%	13 yrs
Gov't Agencies & Muni	0%	3%	11%	11%	13%	15 yrs
Public Utilities	0%	1%	0%	0%	2%	17 yrs
Industrial & Misc	3%	10%	17%	8%	5%	9 yrs
Total	3%	19%	34%	21%	26%	12 yrs

Quality of Bond Portfolio: US Gov't 17.4%; Class 1 - 67.1%; Class 2 8.6% (Total Investment Grade 93.1%). Class 3 - 3.8%; Class 4 - 3.0%; Class 5 - 0.2% (Total Non-Investment Grade 6.9%).

Stocks (4% of admitted assets): Utilities, preferred, $271; industrial and miscellaneous, preferred, $13,139. Total preferred stocks, $13,410; industrial and miscellaneous, common, $8,890; affiliated companies, common, $12,303. Total common stocks, $21,193.

Mortgages (0.0% of admitted assets): Residential mortgages, $57.

Real estate (1% of admitted assets): Home office, $2,970; investment properties, $3,518. The company occupies 141,199 square feet of space for home office purposes (100.0%) for which it pays a rental of $1,694,3[illegible]. Real estate is carried at 86.7% of cost.

Short-term (3% of admitted assets): Bonds, $23,726; other, $802.

INVESTMENT YIELDS

Year	Net Yield	Bonds	Stocks	Mortgages	Cash & Short Term	Real Estate Gross	Real Estate Net
1988	8.13	8.84	5.84	8.44	8.34	4.97	-9.35
1989	8.49	9.27	5.18	6.02	7.77	5.08	-12.98
1990	8.60	9.06	5.90	5.90	7.28	26.29	5.58
1991	7.53	8.18	7.26	6.30	7.35	25.37	2.17
1992	6.73	7.09	7.18	5.87	3.47	26.07	0.33

Note: All ratios are before Federal income taxes. Net yield is for invested assets and is after deduction of investment expenses. Real estate is net after expenses, taxes and depreciation; mortgages are net of servicing fees and commissions.

HISTORY

Incorporated: 11/16/1940 — **Licensed:** 11/16/1940
State of Domicile: IL — **Comm. Ins. Oper.:** 01/07/1941

Current Capitalization: Capital, $3,262,704 (par value $4); paid-in contributed surplus, $14,162,016.

Authorized Shares: 1,000,000 common shares (par value $4), of which 815,676 are outstanding. Also outstanding at year end was a surplus debenture totaling $1,076,361.

Originally incorporated as a burial insurance society with the title Golden Rule Insurance Association, in 1942 the name was changed to Golden Life Insurance Company when it converted to an assessment legal reserve life company. In 1960, the present title was adopted when it merged Golden Rule Insurance Company.

MANAGEMENT AND OPERATIONS

The company operates as a wholly owned subsidiary of Golden Financial Corporation, a Delaware corporation which was formed in

On March 17, 1980, the board of directors of Golden Rule Insurance Company and Golden Rule Life Insurance Company approved a plan whereby the latter company would be merged into Golden Rule Insurance Company. The merger was completed June 30, 1980 following approval of the policyholders of Golden Rule Life Insurance Company, since it was a mutual company, shareholders of Golden Rule Insurance Company and the Illinois Insurance Department.

The affairs of the company are under the direction of chairman of the board J. Patrick Rooney who has been associated with the company since 1958, president and chief executive officer John M. Whelan who has been with the company since 1979, and executive vice president and chief operating officer Therese A. Rooney who has served in multiple capacities with the company since 1978.

Operations are conducted in the District of Columbia and all states (except New York) and are developed through brokerage outlets and special sponsored marketing agreements with several major life insurance companies. Central States Securities, a subsidiary of Golden Rule Financial Corporation, licenses company representatives to sell mutual funds and other equity products. The usual forms of whole life, universal life, term, group life and commercial disability insurance are sold on a non-participating basis.

The company also markets single premium deferred annuities, single premium whole life, and flexible premium annuity contracts, as well as a term life rider for its individual major medical policy. In 1989, the company began marketing long-term care coverage funded through a life insurance policy. In 1991, a life/annuity was introduced which provides retirement living benefits for seniors. During the last seven years, the company's emphasis has continued in the group and individual major medical lines. Collectively these businesses accounted for 78% of net premium writings during 1992.

Golden Rule maintains reinsurance agreements for its life business with several life insurance companies, through which it ceded 11% of its total life insurance in force as of year end. Maximum net retention is $250,000 on ordinary coverages and $30,000 for group business. Virtually all accident and health business is retained by the company.

The regular examination of the company's affairs and condition was conducted as of December 31, 1988 by the Illinois Insurance Department. An annual independent audit of the company is conducted by Price Waterhouse.

Affiliates/Subsidiaries: Life insurance members of the Golden Rule Group include All Savers Insurance Company; Golden Rule Insurance Company, Rooney Life Insurance Company.

Major premium writings by state ($000): Illinois, $91,917 (12.4%); Texas, $77,166 (10.4%); Ohio, $62,125 (8.4%); Florida, $55,748 (7.5%), Connecticut, $38,275 (5.2%); Other, $415,736 (56.1%).

Reserve basis (Current ordinary business): 1980 CSO 5 1/2%, CRVM valuation.

Officers: Chairman of the board, J. Patrick Rooney; president and chief executive officer, John M. Whelan; executive vice president and chief operating officer, Therese A. Rooney; senior vice president, George T. Nasser; vice presidents, Ralph D. Alexander, David W. Brown, J. Andrew Grim, Richard L. Merrill, Susan A. Puotto, Cathleen L. Rooney; vice president, chief financial officer, secretary and treasurer, Randal E. Suttles; vice president and chief actuary, John A. Hartnedy; vice president and actuary, Richard J. Ruppel; vice president and general counsel, Darrell S. Richey.

Directors: Harry L. Davis, Frank S. Ledner, J. Patrick Rooney, Therese A. Rooney, Frank G. Stepker, Randal E. Suttles, Paul J. Weir, John M. Whelan, Thomas L. Whisler.

Territory: Licensed in the District of Columbia and all states except New York.

SIGNIFICANT OPERATING RATIOS

Year	Ord Lapse Ratio %	Average Ord Policy (in dollars) Issued	In Force	Average Premium ($/M) Ord. Only	All Bus.	Renewal Exp. Ratio ($/M) Ord Only	All Bus.
1988	9.7	51,871	67,869	3.91	6.47	3.05	3.02
1989	7.6	67,597	76,140	3.67	3.81	3.38	3.98
1990	9.2	63,599	60,542	6.49	6.52	3.03	3.02
1991	6.6	92,243	77,437	8.37	7.69	3.07	3.19
1992	7.7	123,945	82,172	8.19	7.49	2.75	3.47

ANNUITY STATISTICS
(in thousands of dollars)

Year	Indiv Annuity Reserves	Group Annuity Reserves	Annuity Expense Ratio Indiv (%)	Group (%)	Indiv Annuity Retention Ratio (%)	Avg Size Indiv Annuity (in dollars)
1990	231,788	643	0.28	....	95.04	10,177
1991	290,300	444	0.39	....	90.27	11,332
1992	394,709	412	0.43	....	94.97	11,565

NEW BUSINESS ISSUED
(in thousands of dollars)

Year	Whole Life & Endow.	Term	Credit	Group	Industrial	Total Insurance Issued	Non-Par (%)	Par (%)
1987	172,948	849,278	...	413,117	..	1,335,443	100	..
1988	395,618	2,909,427		9,333	...	3,286,358	100	..
1989	63,902	691,438	...	51,296	....	1,806,636	100	..
1990	36,720	2,068,251	...	90,446	....	2,215,017	100	..
1991	101,988	1,109,565	..	40,236	....	1,260,787	100	..
1992	125,008	797,323		87,408	....	1,009,933	100	.

INSURANCE IN FORCE
(in thousands of dollars)

Year	Whole Life Endow. & Addl	Term	Credit	Group	Industrial	Total Insurance in Force
1987	861,268	1,537,881	..	904,309	....	3,333,458
1988	1,113,834	3,149,158	...	503,482	...	4,766,474
1989	1,006,153	4,439,528		420,791	..	5,866,481
1990	906,387	5,345,139	...	462,821	....	6,714,345
1991	926,850	5,588,453	...	843,317	....	7,358,920
1992	946,552	5,656,543	..	1,304,849	....	7,907,943

COMPANY DEVELOPMENT
(in thousands of dollars)

Year	Admitted Assets	Capital Surplus Funds	Cond'l Reserve Funds	Net Premiums Written	Net Invest Income	Net Gain
1987	302,057	41,436	9,438	307,818	20,850	2,441
1988	367,579	41,496	5,867	406,541	23,253	-14,723
1989	438,173	73,062	7,112	382,360	31,379	18,706
1990	518,220	90,147	200	439,183	38,439	25,368
1991	681,640	117,745	7,978	577,221	49,131	30,136
1992	898,057	140,070	10,053	739,904	50,724	32,143

COMPARATIVE FINANCIAL DATA
(in thousands of dollars)

Year	Net Income	Realized Capital Gains	Unrealized Capital Gains	Interest Maintenance Reserve	Stockholder Dividends	Policyholder Dividends
1988	-17,930	-3,207	-206	....	6,000	464
1989	23,178	4,472	-189	....	..	438
1990	15,495	-8,473	-197	....	9,000	457
1991	41,065	10,929	981	..	6,000	426
1992	34,736	3,394	150	16,745	10,000	415

Profitability Tests

Year	Best's Rating	Ben Paid to NPW	Comm & Exp to NPW	NOG to Tot Assets	NOG to Tot Rev (BT)	Return on Equity	NOG to NPW	Change in C&S
1988	A	63.3	30.8	-4.8	-4.8	24.0	-1.6	32.4
1989	A	60.8	30.7	5.1	4.0	45.1	4.9	76.1
1990	A	56.7	30.3	3.8	7.7	34.7	5.5	23.8
1991	A+	54.9	37.1	5.6	7.4	33.4	5.3	30.6
1992	A+	33.6	25.3	4.7	6.6	23.3	4.3	19.0

Liquidity Tests

Year	Operating Cash Flow($000)	Quick Liquidity	Current Liquidity	Non-Inv Grade Bonds to C&S & AVR	Delinq & Restruct Mtg to C&S & AVR	Mort. & RE to C&S & AVR	Aff'l Invest to C&S & AVR
1988	72,807	31.8	105.8	.	0.C	13.8	18.6
1989	76,752	26.1	115.6	..	..	8.2	11.3
1990	82,190	16.7	114.5	33.2	. .	7.4	10.4
1991	162,531	10.8	116.0	22.8	. .	5.3	11.8
1992	193,056	10.4	114.7	37.8	. . .	4.4	10.2
1992 Best's Adjusted Tests		60.2	60.6	. . .	.	4.2	9.9

GOLDEN RULE INSURANCE COMPANY—Continued

Leverage Tests

Year	C&S to Liabilities	Surplus Relief	Gross Leverage	DPW to C&S	NPW to C&S	Change in NPW
1988	14.8		11.5	6.9	5.8	[illegible]
1989	22.6		3.7	5.2	5.2	-6.4
1990	21.1		3.9	5.1	5.1	20.1
1991	22.3	0.0	4.3	4.9	4.9	25.7
1992	20.1		3.2	5.3	5.3	28.2
1992 Best's Adjusted Tests			3.3	4.8	6.8	

ACCIDENT AND HEALTH STATISTICS
(in thousands of dollars)

Year	Net Premiums Written	Net Premiums Earned	(1) Loss Ratio	(2) Exp. Ratio	(3) Under-Writing Results
1988	330,740	330,534	74.9	34.0	-29,279
1989	331,359	331,577	64.9	31.6	11,703
1990	393,183	384,095	61.8	31.5	21,837
1991	464,221	456,421	53.5	30.1	27,076
1992	576,434	566,907	64.9	28.8	13,415
Current Year Experience:					
Group	225,859	218,986	53.9	36.2	19,206
Collectively renew.	706	711	58.9	22.4	134
Guaranteed renew.	16,919	16,660	60.3	25.4	238
All other	332,951	330,543	73.4	23.4	13,447

(1) Losses incurred plus increase in policy reserves to premiums earned. (2) Underwriting and loss adjustment expenses incurred to net premiums written. (3) Before Federal income taxes and net investment income.

ONE HUNDRED THIRD CONGRESS

JOHN D. DINGELL, MICHIGAN, CHAIRMAN

SHERROD BROWN, OHIO
MARJORIE MARGOLIES-MEZVINSKY, PENNSYLVANIA
HENRY A. WAXMAN, CALIFORNIA
CARDISS COLLINS, ILLINOIS
RON WYDEN, OREGON
JOHN BRYANT, TEXAS
DAN SCHAEFER, COLORADO
CARLOS J. MOORHEAD, CALIFORNIA
JOE BARTON, TEXAS
FRED UPTON, MICHIGAN

REID P.F. STUNTZ, STAFF DIRECTOR/CHIEF COUNSEL

U.S. House of Representatives
Subcommittee on Oversight and Investigations
of the
Committee on Energy and Commerce
Washington, DC 20515-6116

June 16, 1994

VIA FACSIMILE

Mr. John M. Whelan
Chief Executive Officer
Golden Rule Insurance Company
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439

Dear Mr. Whelan:

Pursuant to Rules X and XI of the Rules of the U.S. House of Representatives, the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce is conducting an investigation into the health insurance industry. We are attempting to learn more about several issues, including practices of insurance companies concerning community rating and pre-existing conditions, as well as waste and abuse in the present system.

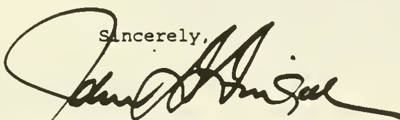
Unfortunately, your company has chosen to ignore the Subcommittee's repeated requests for information critical to the Subcommittee's examination of industry policies and practices. The pattern of Golden Rule's refusal to cooperate with the Subcommittee's inquiry began with its failure to comply fully with the Subcommittee's original March 23, 1994 request for data (enclosed). The Subcommittee subsequently notified Golden Rule in a letter dated May 27, 1994 (enclosed), that the company's April 19, 1994 response had been inadequate, urged the company "to comply fully and expeditiously with the Subcommittee's request for information," and noted that the Subcommittee anticipated scheduling a hearing in late June involving your company. To date, the Subcommittee has received no response to its May letter. Recent staff efforts to contact Mr. Darrell S. Richey, Senior Vice President and General Counsel, have failed, with Mr. Richey's secretary indicating that, "Mr. Richey has been tied up" -- seemingly so for the past several days.

Mr. John M. Whelan
June 16, 1994
Page 2

This letter notifies you that the Subcommittee plans to conduct a public hearing on Wednesday, June 29, 1994, concerning Golden Rule's practices. If you are able to provide the information requested in previous letters by Wednesday, June 22, 1994, then you will be invited to appear. Otherwise, you can expect the Subcommittee to use compulsory process to obtain the needed information, and you will be afforded the opportunity to respond to concerns raised in the June 29 hearing subsequent to the Subcommittee's receipt of the needed information.

Should you have any questions regarding these matters, please contact D.Ann Murphy of the Subcommittee staff at (202) 225-4441.

Sincerely,



John D. Dingell
Chairman
Subcommittee on
Oversight and Investigations

Enclosures

cc: The Honorable Dan Schaefer
Ranking Republican Member
Subcommittee on Oversight and Investigations

JOHN D. DINGELL, MICHIGAN, CHAIRMAN

U.S. House of Representatives
Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce
Washington, DC 20515-6116

May 27, 1994

Mr. John M. Whelan
Chief Executive Officer
Golden Rule Insurance Company
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439

Dear Mr. Whelan:

Pursuant to Rules X and XI of the Rules of the U.S. House of Representatives, the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce is continuing its investigation into financial practices in the health care industry. On March 23, 1994, the Subcommittee requested your company to provide a broad range of information regarding its practices. [That letter is attached.] We received your response on April 20, 1994. The materials you provided, however, were incomplete. The documents did not include responses to questions 2a and 4. Specifically, they included little or no information on Golden Rule's (1) policies on marketing, sales, rating, underwriting, cancellation, and non-renewal procedures and practices for health insurance and (2) compensation packages for the top executive of the company and the executive responsible for the health insurance component of the company.

The information requested is critical to the Subcommittee's investigation of practices in the health insurance industry and their impact on health care costs, access to and quality of care. We urge you, therefore, to comply fully and expeditiously with the Subcommittee's request for information. Specifically, we expect you to provide all information requested and outlined above. Should you fail to comply voluntarily, the Subcommittee will consider taking action to compel the production of the requested materials.

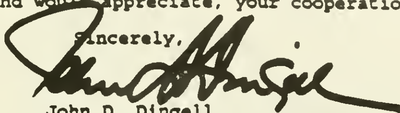
You should also be aware that the Subcommittee plans to conduct a series of hearings on the health insurance industry in the coming months. Subcommittee staff will be contacting you shortly to schedule interviews with you and other company personnel familiar with these issues. Additionally, the Subcommittee anticipates scheduling the first hearing in its

Mr. John M. Whelan
May 27, 1994
Page 2

series at the end of June, and expects to request testimony from you or that of another company representative at that hearing. Should you have any questions regarding any of these matters, please contact D.Ann Murphy of the Subcommittee staff at (202) 225-4441.

We anticipate, and would appreciate, your cooperation and assistance.

Sincerely,



John D. Dingell
Chairman
Subcommittee on
Oversight and Investigations

cc: The Honorable Dan Schaefer
Ranking Republican Member
Subcommittee on Oversight and Investigations

JOHN D. DINGELL, MICHIGAN, CHAIRMAN

SHERROD BROWN, OHIO
MARJORIE MARGOLIES-MEZVINSKY, PENNSYLVANIA
HENRY A. WAXMAN, CALIFORNIA
CARDISS COLLINS, ILLINOIS
RON WYDEN, OREGON
JOHN BRYANT, TEXAS
DAN SCHAEFER, COLORADO
CARLOS J. MOORHEAD, CALIFORNIA
JOE BARTON, TEXAS
FRED UPTON, MICHIGAN

REID P.F. STUNTZ, STAFF DIRECTOR/CHIEF COUNSEL

U.S. House of Representatives
Subcommittee on Oversight and Investigations
of the
Committee on Energy and Commerce
Washington, DC 20515-6116

March 23, 1994

Mr. John M. Whelan
Chief Executive Officer
Golden Rule Insurance Company
Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1717

Dear Mr. Whelan:

Pursuant to Rules X and XI of the Rules of the U.S. House of Representatives, the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce is continuing its investigation into financial practices in the health care industry. Previous inquiries and public hearings over the last three years have focused on the hospital industry, individual providers, the home infusion industry and the adequacy of state and federal oversight of them. We have examined a broad range of financial practices and evolving trends in organizational structures and financial relationships to determine their impact on health care costs, access and quality. And we have examined the extent and nature of waste and fraud in the existing system. As part of this probe, we are now examining the policies and practices of health insurance companies. These major areas of concern are outlined below.

First, the policies and practices of insurance companies concerning community rating and pre-existing conditions are at the center of the present legislative debate. Claims have been made, for example, that high-cost individuals are arbitrarily dropped, that wholesale exclusions are made for pre-existing conditions, and that many insurance companies "cherry pick" young, healthy, low-risk people. We need to learn more about relevant policies and practices.

Second, the Subcommittee has reviewed the performance of many companies as fiscal intermediaries (FIs). Unfortunately, analyses conducted by both the Office of Inspector General (IG) of the Department of Health and Human Services and the General Accounting Office (GAO) have raised serious questions regarding how FIs spend the nearly $2 billion they receive annually to serve as the Department's agents in paying Medicare and Medicaid bills and tracking those monies. Their work suggested that

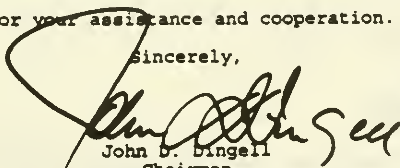
millions of dollars are lost due to the fact that the FIs too often become mere claims processors, not auditors. Often, neither the FIs nor the Department know whether Medicare and Medicaid monies are spent wisely and appropriately, or whether the taxpayers' coffers are being pillaged by greedy and/or incompetent providers. Equally disturbing, concerns regarding potential conflicts of interest in the FIs' own involvement and inherent vested interest in those programs were raised by the IG in testimony at a Subcommittee hearing last month. The IG testified, for example, that there were few, if any, incentives for FIs to identify primary payers liable for bills under the Medicare Secondary Payer provisions; they themselves could end up picking up the tab rather than the taxpayers.

Third, the Subcommittee is concerned that there is too much waste and abuse in the health care system. Many witnesses who have testified before the Subcommittee, including some industry officials, warned that millions if not billions of taxpayer dollars are being lost as unnecessary overhead charges, inflated pricing policies, bloated executive compensation packages and outright fraud have not only crept into the system, but have been allowed to run rampant. Identifying the existing flaws and the resulting "fat" built into the health care delivery system is critical in order to assess how best to curb escalating costs in the least painful, least destructive and most constructive manner.

In order to assist the Subcommittee in more fully assessing how the health insurance industry functions and in addressing these concerns, you are requested to provide the information requested in Attachment A by close of business on Wednesday, April 20, 1994. We do not intend to impose an undue burden by this request; but we would appreciate your company's best efforts to provide meaningful information. Should you have any questions regarding this request, please contact D.Ann Murphy of the Subcommittee staff at (202) 225-4441.

Thank you for your assistance and cooperation.

Sincerely,



John D. Dingell
Chairman
Subcommittee on
Oversight and Investigations

Enclosure

cc: The Honorable Dan Schaefer
Ranking Republican Member
Subcommittee on Oversight and Investigations

ATTACHMENT A

1. General Information

a. Please list and describe all types of health insurance (i.e., managed care plans, fee-for-service, etc.) offered by your company and the states in which they are offered. All information should cover calendar years 1990-1993.

b. For calendar years 1990-1993, please provide the company's gross premium and net income generated each year, broken down by each type of health insurance offered.

c. Please list all other affiliates and/or subsidiaries engaged in any aspect of health insurance business, the type of business they are engaged in, and the gross premium and net income generated by each.

d. Please list all affiliates and/or subsidiaries engaged in the provision of health care or health-related services.

2. Rating and Pre-existing Condition Information

a. Please provide copies of all policy statements, descriptions of practices, and guidelines to company employees and agents that define your company's marketing, sales, rating, underwriting, cancellation, and non-renewal procedures and practices for health insurance.[1]

1) Do you consider the following factors in determining the insurability or premium rate for new applicants, or cancellation or non-renewal of existing policies (mark all that apply):

Risk Category	Insurability	Premium Rate	Cancellation and Non-renewal
Age			
Sex			
Geographic Area			
Smoker			
Medical History			
Physical Condition			
Financial Status			

2) Would you describe your current rating practices to be consistent with "modified community rating"? If so, please describe briefly how they are consistent. If not, describe briefly your rating practices.

b. For each state in which you write health insurance, and for each type of health insurance policy (individual, small

group, large group, HMO, etc.), provide the following information for each year 1990-1993.

1) Pre-application Screening Procedures

* The number of initial agent or company contacts with prospective customers by your company or by agents (whether employees or independent).

* The most significant reasons (at least five) why some prospective customers did not proceed to make application and the number attributable to each of those reasons.

* Please send a copy of all guidance to agents concerning anything that could be construed to be pre-application screening of prospective customers.

2) Application Screening Procedures

* The number of applications for health insurance.

* The number of applications that were rejected.

* The most significant reasons for rejected applications (at least five) and the number of rejections attributable to each of those reasons.

3) Cancellation and Non-renewal Procedures

* The number of cancellations and non-renewals.

* The most significant reasons for cancellation or non-renewal of policies (at least five) and the number attributable to each of those reasons.

c. In soliciting new business, does your company target customers based on (1) geographic region, (2) classes of risks (e.g., based on historical firm or industry demographic statistics), (3) economic characteristics, i.e., income level, (4) occupation, or (5) any other screening criteria? Please describe your answer fully. Please send a copy of all documents describing these screening policies and the procedures you use to implement them in your company.

d. Please describe the kinds of information required to be

kept by agents, whether employees or independent.

3. Fiscal Intermediaries

a. Please indicate whether the company serves as a fiscal intermediary (FI) for the Health Care Financing Administration (HCFA), and if so, in what geographic areas the company performs those functions. The description should cover calendar years 1990-1993. In addition, please indicate what specific functions the company performs, i.e., regional FI processing home health care claims, organ transplant claims, etc.

b. If the company is an FI, please provide the dollar amount received from HCFA for those activities in 1990-1993.

4. Overhead Information

a. For the years 1990-1993, please provide the annual salary of the company's top executive.

b. For the years 1990-1993, please provide the annual salary for the top executive responsible for the health insurance component of the company.

c. For the years 1990-1993, please provide a complete listing of all other items included in the compensation packages of the two executives described above. That list should encompass all "fringe benefits," including, but not limited to, bonuses, health insurance, pension plans, stock options, "golden parachute" provisions, housing, transportation, travel, meals, loans, and educational subsidies.

Definition of Insurance Terms

Cancellation -- The termination of an insurance policy prior to its renewal date. The policy may be canceled by an insured or insurer as stated in the policy. If an insurance company cancels a policy, any unearned premiums must be returned. If an insured cancels the policy, an amount less than the unearned premiums is returned, reflecting the insurance company's administration costs of placing the policy on its books.

Community Rating -- Pure community rating exists when the premium rates (see below) charged to individuals for health insurance are based on the costs of providing coverage to a broad population of policyholders, without variations due to individual circumstances or conditions.

HMO -- Health Maintenance Organization is a prepaid group health insurance plan which entitles members, who pay a flat periodic fee, to services of participating physicians, hospitals, and clinics.

Insurability -- Circumstance in which an insurance company can issue life or health insurance to an applicant based on standards set by the company.

Modified Community Rating -- Requires insurers to ignore factors like pre-existing conditions when setting rates for individual policyholders, but allows some policy rate variations for certain other demographic or geographic factors, for example, the age of the insured.

Non-renewal -- Circumstance in which an insurance company declines to renew an expiring policy.

Premium Rate -- The premium rate is the amount an insured is charged, reflecting his/her expectation of loss or risk. The insurance company will assume the risks of the insured in exchange for a premium payment. Premiums are calculated by combining expectation of loss and expense and profit loadings.

Rating Policy -- The policy used to calculate a premium so that it is adequate, reasonable, and does not unfairly discriminate or is inequitable.

Underwriting -- Process of examining, accepting, or rejecting insurance risks, and classifying those selected, in order to charge the proper premium for each.

THE LAW FIRM OF
KEVIN S. HANNON
1600 BROADWAY STREET
SUITE 2000
DENVER, COLORADO 80202-4920

TELEPHONE (303) 861-8500

November 15, 1991

Stephen J. Hough, Esq.
Croegaert, Calrk & Hough, Ltd.
305 E. Main Street
Olney, IL 62450

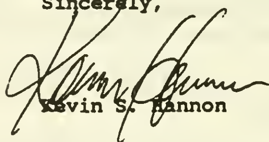
Re: Golden Rule Insurance Company

Dear Stephen:

In preparing our Golden Rule case, we found the enclosed document at the Commissioner of Insurance. This document is a very important document with regard to Golden Rule's claim in our case that there has been a material misrepresentation based on a pre-existing condition.

I would appreciate your help in getting to Golden Rule on this issue. First, if you would be so kind to volunteer your time to determine whether a similar letter was sent to the Commissioner of Insurance in your state, and pass along a copy to me. Second, if you obtain any discovery with regard to this issue, I would appreciate greatly having a copy of that. We will be glad to pay for copying expenses. We will also be glad to provide you with any copies of documents that we get in discovery, particularly with regard to this pre-existing condition issue.

Sincerely,



Kevin S. Hannon

gr

Enc.

W. H. ODELL & Associates, Inc.
Actuarial Services of the South
SUITE A AMERICAN BUILDING
1400 OLD MILL CIRCLE
WINSTON-SALEM, NC 27103

W. H. ODELL, FSA, ACAS, FCA, MAAA, EA
EDWARD R. SHUGART, III, FSA, FCA, MAAA, EA

TELEPHONE
919-768-8217

October 25, 1988

COLORADO
RECEIVED
OCT 26 1988
DIVISION OF
INSURANCE

Commissioner John Kezer
Commissioner of Insurance
Colorado Department of Insurance
106 State Office Building
Denver, CO 80203

Dear Commissioner Kezer:

Golden Rule Insurance Company has retained W.H. Odell & Associates, Inc. to independently assess what must be done in light of the company's rapid increase in health insurance claim costs this year on individual major medical insurance.

Golden Rule brought us in because one of the areas of special interest and expertise of our firm is actuarial work for individual health insurance. We have had extensive experience with individual health insurance.

Golden Rule is experiencing severe financial losses in 1988 on their individual major medical insurance. We have made our own independent projections for the remainder of 1988 and into 1989. We see disastrous results ahead for the company unless very substantial additional rate actions are taken for 1989. We asked the company to also make projections using different procedures. These additional projections showed the same unacceptable results.

Part of the reason for their severe losses has been the company's decision to be liberal in respect to preexisting conditions. The policy excludes preexisting conditions for only one year, and the definition of preexisting conditions refers to what has happened in only the last two years before the insurance went into effect. That's very liberal treatment of preexisting conditions, which is beneficial to the public but it's been very hard upon Golden Rule. Their claim cost after the first policy year is far above what was anticipated when the policy was filed.

The individual health insurance of the company may be divided into the following classifications

1. Policy Form GR-I-H-1.1 (major medical expense insurance which is the subject of this filing)

2. High deductible (deductible of $5,000 and up) coverages of the same general type as category 1.

3. Various other coverages

Commissioner John Kezer
October 25, 1988
Page 2

Form GR-I-H-1.1 is the most important, accounting for 71.8% of projected 1988 earned premium, and most urgently needs attention. Therefore, it is addressed by this filing.

We have worked out with the company the following strategy:

1. Overall rate action.

   They would make a major rate increase to be effective January 1, 1989, which is described in the actuarial memorandum that accompanies this letter.

2. Product design.

   For new policy form offerings apply acquired experience to attempt elimination of benefits which are very costly in relation to their expected value to those policyholders who are conscientious about health maintenance and about the use of claim dollars.

3. $100 deductible plan.

   The most severe losses are on the $100 deductible plan. At the same time that the $100 deductible policies get a rate increase, the company will offer the policyholders the opportunity to change to a $350 deductible which will cost less than rate they would otherwise have to pay

We believe that this strategy will provide policyholders in your state a better outcome than they otherwise would have. This requires immediate action, because the company needs to mail to the policyholders by November 25:

1. notice of a rate increase to be effective January 1; and

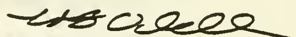
2. the offer to reduce the premium by changing from $100 deductible to $350 deductible.

We understand that this filing is all that is needed and the company will proceed with the rate level change.

If you wish additional information, please phone me and we will get it to you immediately.

If you want someone from our firm to come to talk with you, we will be pleased to do that.

Sincerely,



W. H. Odell
FSA, ACAS, FCA, MAAA, EA

RECEIVED
Golden Rule®
94 JUN 27 AM 11:10
SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

The Honorable John D. Dingell
Chairman, Subcommittee on
Investigations & Oversight
Committee on Energy &
Commerce
U.S. House of Representatives
Washington, D.C. 20515-6116

June 24, 1994

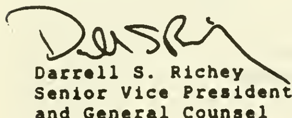
Dear Mr. Dingell:

As indicated in my June 22, 1994 faxed letter, here are additional materials in response to requests 2a which was attached to you original March 23, 1994 letter. This supplements our response of April 19, 1994.

According to our Actuarial Department, we do not have any specific written guidelines or procedures regarding rating practices (pricing and repricing). Based on Golden Rule's experience, we realize what loss ratios we can operate at and still have sufficient margins to cover expenses, overhead and a small profit. Based on this knowledge, we price and reprice our products to attain certain levels of loss ratios based on current experience. When a new product is developed, we will make reference to the Transactions of the Society Actuaries or other studies to develop claim costs figures.

We trust that this material, together with all the information provided in our earlier response, will be satisfactory.

Very truly yours,



Darrell S. Richey
Senior Vice President
and General Counsel

DSR/ala

cc: The Honorable Dan Schaefer
Ranking Republican Member
Subcommittee on Oversight
& Investigations (w/o attachments)

Golden Rule Insurance Company

Home Office
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439
Telephone (618) 943-8000

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

Golden Rule®

The Honorable John D. Dingle
Chairman, Subcommittee on
Investigations & Oversight
Committee on Energy &
Commerce
U.S. House of Representatives
Washington, D.C. 20515-6116

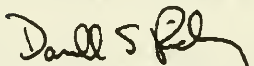
June 22, 1994
FAX # 202 225-2899

Dear Mr. Dingle:

We are in receipt of your June 16, 1994 letter. We did give you a timely response to your original request for information. With the exception of the request regarding compensation, we did respond to your requests.

We understand that you were not satisfied with the material produced in response to one request and we are in the process of pulling additional documents together. We would expect to be able to send more material out under a separate cover by Friday noon. Due to the volume of material, it would not be practical to fax it. We will send this by Express Courier Service for Monday delivery.

Very truly yours,



Darrell S. Richey
Senior Vice President
and General Counsel

DSR/ale

cc: The Honorable Dan Schaefer
Ranking Republican Member
Subcommittee on Oversight
& Investigations

D. Anne Murphy
Subcommittee Staff

Golden Rule Insurance Company
Home Office
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439
Telephone (618) 943-8000

Golden Rule Insurance Company
Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

Golden Rule

The Honorable John D. Dingell
Chairman,
Subcommittee on Oversight
and Investigations
U.S. House of Representatives
Room 2323
Rayburn House Office Building
Washington, D.C. 20515-6116

April 19, 1994

Re: Your letter of March 23, 1994

Dear Congressman Dingell:

I have been asked to respond to the above referenced letter addressed to our CEO, Mr. John M. Whelan.

We understand your concerns about the health care system. Health care financing, especially health insurance companies, are an integral part of the health care system.

Enclosed is our response to the specific information requested in Attachment A to your letter. I hope you find this information helpful.

I would also like to respond to some of the points raised in your letter.

I occasionally hear anecdotes about high cost individuals who are arbitrarily dropped because the ''evil'' insurance company decided they were too expensive. This is certainly not a normal industry practice. We have never engaged in this behavior. I don't know of any responsible insurer that does. We have many insureds with claims totaling $500,000 or more and some with claims as much as $1,000,000.

Similarly, I frequently hear the term ''cherry-picking'' misused. Traditionally, the term ''cherry-picking'' referred to the practice of terminating a broad group of insureds and then selectively soliciting the healthy risks to purchase replacement coverage with your company. We have always strongly opposed this practice because it leaves all the less healthy insureds out in the cold-looking for insurance.

Golden Rule Insurance Company

Home Office
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439
Telephone (618) 943-8000

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

Congressman Dingell
Page 2
April 19, 1994

To avoid even the possible appearance of ''cherry-picking,'' we do not allow a former insured to buy our insurance for a full twelve months, even if the former insured voluntarily dropped his or her insurance with us. This rule also reduces the temptation for a broker to obtain a new first-year commission by rewriting an existing insured.

To use the term ''cherry-picking'' as a derogatory reference to insurance underwriting is clearly misplaced. Underwriting is the essence of any true insurance plan, whether it is life insurance, fire insurance, auto insurance or even health insurance. Without underwriting, a so-called ''insurance'' plan is really nothing more than claims administration.

Not individually underwriting may work for larger group purchasers, but it will not work for individual and small group health insurance. This is why the large group health insurers have abandoned these markets, preferring to concentrate on the less risky and more lucrative business of claims administration and managing health care. These companies now prefer to refer to themselves as ''managed care organizations.''

In the individual and small group health insurance environment, adverse selection makes it impossible for the market to survive without underwriting. The recent experience in New York state has demonstrated this truth dramatically. Young, healthy, low risk individuals will not voluntarily subsidize older, less healthy, high risk individuals. Without underwriting, costs skyrocket and only those people who expect to have claims greater than their premium will want to play.

Let me give you a couple of analogies. If a fire insurer allowed burning buildings to be insured, premiums would immediately and dramatically increase. Responsible insureds would not stay with that insurer. If a life insurer issued life insurance to all applicants without underwriting, no reasonably healthy person would want to

Congressman Dingell
Page 3
April 19, 1994

be insured by that insurer. Without underwriting, a company must raise premiums dramatically or go broke.

More than 85% of Americans have health insurance. For most of the 37 million or so Americans without health insurance, it is a problem of affordability, not accessibility.

We believe that any reform of health care financing should not destroy the strength of the current system in an effort to solve the problems of a minority who have difficulty in accessing this system.

Access problems should be solved by reforms that:

(1) encourage individuals to control their own medical costs;

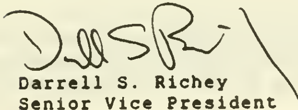
(2) encourages those who are not in the health insurance system to get into the health insurance system while they are still healthy;

(3) encourage those who are currently in the health insurance system to stay in the health insurance system;

(4) directly assist those who are uninsurable; and

(5) assist those who cannot afford coverage by providing tax fairness, including expanded tax credits for low income families.

Sincerely,



Darrell S. Richey
Senior Vice President

DSR/ala

RESPONSES TO REQUESTS FOR INFORMATION

REQUEST #1.a.

Please find attached a chart showing the types of health insurance offered by Golden Rule and the states in which they were offered for calendar years 1990 - 1993.

REQUEST #1,b.

Please find attached a chart showing Golden Rule's gross premium and net income generated for the years 1990 - 1993 broken down by type of health insurance offered.

REQUEST #1.c.

Golden Rule has no affiliates and/or subsidiaries engaged in any aspect of health insurance business.

REQUEST #1.d.

Golden Rule has no affiliates and/or subsidiaries engaged in the provision of health care or health-related services.

REQUEST #2.a.

Much of this type of information is propriatary and confidential trade secrets, nevertheless, without waiving this privilege, we have attached a copy of our "Information for All Golden Rule Producers."

REQUEST #2.a.(1)

Risk Category	Insurability	Premium Rate	Cancellation and Non-renewal**
Age	X	X	
Sex		X	
Geographic Area		X	
Smoker		X	
Medical History	X		
Physical Condition	X		
Financial Status			

** We do not use any of these factors. Fraud, misrepresentations, and failure to comply with policy requirements are the most common reasons for cancellation by us. However, more than 98% of all cancellations are initiated by the insureds. Nonrenewals are done on a statewide basis and are generally due to a change in the laws or regulations in a given state that put our policies not in compliance.

REQUEST #2.a.(2)

It varies according to the type of plan. The rates of individual insureds and for small employer groups do not take account of the health of the individuals or small groups. Large employer groups are sometimes experience-rated.

REQUEST #2.b(1)

Pre-application Screening Procedures:

Golden Rule does not permit field medical underwriting or pre-screening of prospective customers by any of the producers (agents or brokers) who offer our health products. Therefore, we do not have any information available regarding pre-application screening procedures.

REQUEST #2.b.(2)

Application Screening Procedures:

- Attached are charts for 1990, 1991, 1992, and 1993 showing the number of health applications received for each of those years by state, by product. Please note we do not have information available for group, 1990.

- Attached are charts for 1990, 1991, 1992, and 1993 showing the number of applications rejected for each of those years by state, by product. Please note we do not have information available for group, 1990.

- The most significant reasons for rejected applications and the number of rejections attributable to each is not available. Based on our experience, we believe the primary reasons for rejection are insufficient premium, incomplete applications or other failures to comply with administrative requirements, insufficient information for underwriting, health status and the fact that the applicant or dependents already have other insurance. The reasons why applicants withdraw their applications is not available.

REQUEST #2.b.(3)

Cancellation and Non-renewal Procedures

- Attached is a chart showing the number of cancellations or non-renewals for the years 1990, 1991, 1992, and 1993. Information by type of business was not available.

- The most significant reasons for cancellation or non-renewal is not available. More than 98% of the cancellations were initiated by the insureds. The non-renewals are done on a state-wide basis and are due to a change in the law or regulations that put our policies not in compliance.

REQUEST #2.c.

Golden Rule does not target customers based on any of these criteria.

We understand that some companies refuse to accept low income customers due to the high lapse ratio which can reasonably be expected. We do not refuse applicants based on income level or occupation. In fact, approximately 30% of our individual insureds have family incomes of $15,000 or less.

REQUEST #2.d.

Golden Rule does not require any information be kept by agents, whether employees or independent.

REQUEST #3.

Not applicable. We do not serve as a fiscal intermediary for HCFA.

REQUEST #4.

We are a closely held company and this information is confidential.

Request 1.b.

Gross Premium

	1990	1991	1992	1993
Individual Health	357,305,145	354,196,741	350,533,849	319,544,394
Large Employer Group	8,796,212	8,696,094	8,692,832	7,766,603
Small Employer Group	18,997,561	17,590,070	21,050,902	27,709,917
Association Group	5,269,845	81,475,123	195,730,080	257,868,282
Total A & H	390,368,763	461,958,028	576,007,663	612,889,196

Net Income#

	1990	1991	1992	1993
Individual Health	N/A	N/A	12,628,699	18,154,504
Large Employer Group	N/A	N/A	383,354	881,802
Small Employer Group	1,783,442	2,022,478	977,872	875,279
Association Group	(665,162)	765,764	14,923,118	15,327,143
Total A & H	22,903,585	26,460,764	28,913,043	35,238,728

Including investment income on shareholder equity, which is distributed in these numbers.

Request 2.a.

INFORMATION FOR ALL GOLDEN RULE PRODUCERS

NOVEMBER, 1993

Published by
Golden Rule Insurance Company
Copyright © 1993 Golden Rule Insurance Company

INFORMATION FOR ALL GOLDEN RULE PRODUCERS

We at Golden Rule are pleased to be working with you.

We are providing this publication to make you aware of things you can do to help us better serve you and your clients.

There is additional information contained in the product brochures. You may receive periodic notices of revised or new information. This information will also be considered a part of the Company's rules and regulations. We encourage you to read and keep this publication and all other notices where they can be referred to as questions or problems arise. Revisions, additions, or deletions to the rules and regulations will be deemed to be in your possession seven days after they have been mailed to you.

GENERAL RULES

To maintain our good reputation and yours, you are expected to comply with all applicable insurance laws and regulations.

Your authority to act on behalf of Golden Rule is limited. You may not obligate or bind the Company in any manner (such as issuing binders; giving statements contrary to established Golden Rule policy; or offering personal assurances to policyholders, certificateholders, or applicants concerning issues of underwriting, claim resolution, or coverage.)

Your relationship with Golden Rule is that of an Independent Contractor. You should keep the Company informed of the following information: your address, telephone number, states in which you are licensed, and the status of your E&O coverage (whether provided by yourself or your employer). All materials furnished to you, including rate manuals (either in disk form or hard copy) must be returned upon request. Such material may also be considered proprietary information of Golden Rule and your disclosure of such information prohibited. If you are in doubt of what material may be disclosed, please contact Golden Rule.

LICENSING

In addition to having a Broker's Contract with Golden Rule, you must be licensed in the state or states from which you intend to submit applications for insurance. We require your licensing be complete before you submit any application to us. We will notify you when your licensing has been approved and you may begin soliciting applications for Golden Rule products.

In states that send renewal license information directly to the licensee, it is very important that you furnish Golden Rule with a copy of your renewal license. Unless your current license is on file with Golden Rule, any application you submit will be returned to you.

You may not sign an application for another producer. Such action may subject you to termination and/or personal liability.

You may verify your license status and authorization to offer Golden Rule products by contacting your Golden Rule Regional Marketing Office. (If you are under a Sponsored Marketing Agreement, contact the Sponsored Marketing Unit at the Executive Office.)

COMMISSIONS

Commission checks are mailed on the fifth working day of each month and are paid on business actually issued through the last day of the preceding month. During your first year as a broker, commission checks will be issued regardless of the amount due. After your first year, if the commission due is less than $50, no payment will be made and commissions will be left to accumulate until at least $50 in commissions is payable.

Commission is not paid on new applications until the policy has been issued and the premium has been received by Golden Rule.

Please wait at least sixty (60) days following submission of an application to inquire about unpaid commissions. When you do have questions, your inquiry should be directed to your Golden Rule Regional Marketing Office. (If you under a Sponsored Marketing Agreement, contact the Sponsored Marketing Unit at the Executive Office.)

ADVERTISING

Only Golden Rule approved advertising materials may be used. Product brochures, information kits, ad mats, and promotional "stuffers" are available for your use.

Do not change or modify the format of Golden Rule advertising material supplied to you.

For standard advertising materials and sales aids, you may contact your Regional Marketing Office or complete the requisition form which is available in each Product Marketing Kit.

If you want to use the Golden Rule name or logo in any advertising material, or in any other manner, you must first obtain written approval from Golden Rule.

APPLICATIONS, PREMIUMS, AND UNDERWRITING

When submitting applications to us, please assure that the applicant accurately completes all forms, unless the form is specifically designed to be completed by you. Either way, be sure the applicant carefully reviews the completed application prior to signing and dating it in your presence. Never allow an applicant to sign a blank or incomplete application.

Please be certain the applicant fully completes the application, paying particular attention to the health history questions and "other insurance" questions.

ALL APPLICATIONS MUST BE SUBMITTED WITHIN THREE (3) WORKING DAYS OF THE DATE ON THE APPLICATION. APPLICATIONS MORE THAN FIFTEEN (15) DAYS OLD WHEN RECEIVED WILL BE RETURNED. APPLICATIONS MUST BE DATED BY THE APPLICANT ON THE DATE THE APPLICATION IS SIGNED.

Golden Rule does not accept COD health business or trial applications. Any submission without the initial premium will be returned.

Golden Rule will accept COD life business only in the following situations:

- Cases of life insurance in which the aggregate amount of life insurance in force or applied for with Golden Rule will equal or exceed $300,000.
- Cases of life insurance in which any person to be covered has experienced stroke, heart attack, diabetes, or cancer (other than skin cancer); or
- If the policy will be funded via a Section 1035 Exchange (in which case the tax form must be submitted with the application).

Premium checks should be made payable to Golden Rule and submitted with the application. Partial payments cannot be accepted unless specifically provided for in the product information.

Only initial premiums are to be collected and submitted with the application. Subsequent premiums will be billed directly by Golden Rule to the insured and the insured will make all payments directly to Golden Rule.

With regard to health products for individuals and small groups, the earliest possible effective date is the date the application, premium, and supporting material (if required) are received at the Home Office or Executive Office of Golden Rule Insurance Company.

PLEASE DO NOT SUBMIT ALTERED APPLICATIONS.

Coverage-restriction riders attached to any issued policy will be reviewed upon written request if:

- Six months have elapsed for one-year riders; or
- One year has elapsed for riders with a duration of more than one year.

CLAIMS

Golden Rule makes every effort to assure fast, accurate, and fair claims handling. You can best serve your client by encouraging the claimant to cooperate in the collection of all medical records necessary for a complete and proper [illegible].

Producers should not offer opinions about claims to insureds or other persons. Decisions on all claims will be made by the Claim Department based on information submitted by the insured and the provider of the medical service

INFORMATION SOURCES

Claims/Account Servicing: Should you receive a question from an insured or a provider regarding a claim please refer them to Golden Rule's Client Services Division at the location and telephone number shown on the back of the policyholder/certificateholder's identification card.

Marketing Opportunities: Refer all marketing questions and problems to your Golden Rule Regional Marketing Office. (If you are under a Sponsored Marketing Agreement, contact the Sponsored Marketing Unit at the Executive Office.) Please stay within the designated communication channels so that the duplication of efforts is avoided

Golden Rule®

Golden Rule Insurance Company

Home Office
Golden Rule Building
712 Eleventh Street
Lawrenceville, Illinois 62439

669-1093
Copyright © 1993 Golden Rule Insurance Company

Request 2.b.2.

1990

Applications Received

	Small* Employer Group	Large* Employer Group	Association Group	Individual
ALABAMA			0	1,459
ALASKA			54	573
ARIZONA			613	5,016
ARKANSAS			650	3,906
CALIFORNIA				
COLORADO			1,130	7,429
CONNECTICUT				18,033
DELAWARE				779
FLORIDA			2,456	19,778
GEORGIA				2,075
HAWAII				
IDAHO				80
ILLINOIS			3,089	17,282
INDIANA			510	6,627
IOWA			356	4,663
KANSAS			548	2,347
KENTUCKY			977	5,922
LOUISIANA			1,909	13,149
MAINE				3,513
MARYLAND				5,427

* N/A for 1990

Chart for Request #1.a.

PLANS AVAILABLE FOR

1990 THROUGH 1993

STATE	SMALL EMPLOYER GROUP	LARGE EMPLOYER GROUP	ASSOCIATION GROUP	INDIVIDUAL
ALABAMA	X	X	91-93	X
ALASKA	N/A	X	X	X
ARIZONA	X	X	X	X
ARKANSAS	X	X	X	X
CALIFORNIA	N/A	N/A	N/A	N/A
COLORADO	X	X	X	X
CONNECTICUT	X	N/A	N/A	X
DELAWARE	X	N/A	91-93	X
FLORIDA	X	X	X	X
GEORGIA	X	90-92	N/A	X
HAWAII	N/A	N/A	N/A	N/A
IDAHO	91-93	X	N/A	X
ILLINOIS	X	X	X	X
INDIANA	X	X	X	X
IOWA	X	X	X	X
KANSAS	90-91	90-91	N/A	X
KENTUCKY	X	X	X	X
LOUISIANA	X	X	X	X

X = Available in each of the fours years
N/A = Not available in any year

Page 2 of 3
Chart for Request #1.a.
1990-1993

STATE	SMALL EMPLOYER GROUP	LARGE EMPLOYER GROUP	ASSOCIATION GROUP	INDIVIDUAL
MAINE	N/A	N/A	N/A	X
MARYLAND	X	N/A	X	X
MASSACHUSETTS	N/A	N/A	N/A	X
MICHIGAN	X	X	X	X
MINNESOTA	N/A	N/A	N/A	X
MISSISSIPPI	X	93	91-93	X
MISSOURI	X	X	X	X
MONTANA	N/A	N/A	N/A	N/A
NEBRASKA	X	X	X	X
NEVADA	91-93	N/A	N/A	X
NEW HAMPSHIRE	90	N/A	N/A	X
NEW JERSEY	N/A	N/A	N/A	N/A
NEW MEXICO	90-92	90-92	N/A	X
NEW YORK	N/A	N/A	N/A	N/A
NORTH CAROLINA	N/A	N/A	N/A	X
NORTH DAKOTA	93	X	N/A	X
OHIO	X	X	X	X

X = Available in each of the fours years
N/A = Not available in any year

Page 3 of 3
Chart for Request #1.a.
1990-1993

STATE	SMALL EMPLOYER GROUP	LARGE EMPLOYER GROUP	ASSOCIATION GROUP	INDIVIDUAL
OKLAHOMA	X	X	X	X
OREGON	91-93	90-93	N/A	X
PENNSYLVANIA	N/A	N/A	N/A	X
RHODE ISLAND	N/A	N/A	N/A	N/A
SOUTH CAROLINA	92-93	90-93	N/A	X
SOUTH DAKOTA	X	X	N/A	X
TENNESSEE	X	X	X	X
TEXAS	X	X	X	X
UTAH	X	X	N/A	X
VERMONT	N/A	N/A	N/A	90-92
VIRGINIA	X	X	X	X
WASHINGTON	N/A	N/A	N/A	X
WEST VIRGINIA	92-93	90-92	91-93	X
WISCONSIN	X	X	X	X
WYOMING	N/A	90-92	N/A	X

X = Available in each of the fours years
N/A = Not available in any year

1991

Applications Received

	Small Employer Group	Large Employer Group	Association Group	Individual
ALABAMA	6	0	486	843
ALASKA	1	0	465	166
ARIZONA	13	0	1,744	2,639
ARKANSAS	132	26	3,001	1,773
CALIFORNIA				
COLORADO	193	0	4,206	4,656
CONNECTICUT				21,540
DELAWARE			462	416
FLORIDA	2	24	11,171	9,892
GEORGIA	22	7		2,022
HAWAII				
IDAHO				52
ILLINOIS	1,395	140	12,539	13,054
INDIANA	619	97	4,258	5,157
IOWA	113	0	2,292	2,568
KANSAS	74	0	1,030	1,071
KENTUCKY	565	32	4,117	3,719
LOUISIANA	488	4	8,058	6,451
MAINE				1,654
MARYLAND			3,012	2,864

1991

Applications Received

	Small Employer Group	Large Employer Group	Association Group	Individual
MASSACHUSETTS				821
MICHIGAN	532	2	8,984	12,329
MINNESOTA				3,329
MISSISSIPPI	21	0	251	781
MISSOURI	413	14	3,186	4,053
MONTANA				
NEBRASKA	68	0	1,736	1,429
NEVADA	2	0		459
NEW HAMPSHIRE				6,235
NEW JERSEY				
NEW MEXICO	26	0		718
NEW YORK				
NORTH CAROLINA				1,808
NORTH DAKOTA				1,466
OHIO	1,299	44	13,875	14,513
OKLAHOMA	52	0	3,336	1,806
OREGON				247
PENNSYLVANIA				1,540
RHODE ISLAND				
SOUTH CAROLINA				7,020

1991

Applications Received

	Small Employer Group	Large Employer Group	Association Group	Individual
SOUTH DAKOTA	12	0		3,074
TENNESSEE	486	63	7,828	6,665
TEXAS	164	59	13,521	13,474
UTAH				567
VERMONT				5,304
VIRGINIA	562	13	6,629	4,922
WASHINGTON				176
WEST VIRGINIA	12	0	279	1,175
WISCONSIN	217	1	7,355	6,878
WYOMING				355

Request 2.b.2

Applications Rejected and
Withdrawn by Applicants

	Small* Employer Group Certificates	Large* Employer Group Certificates	Association Group Certificates	Individual Policies
ALABAMA				93
ALASKA			1	77
ARIZONA			74	450
ARKANSAS			64	355
CALIFORNIA				
COLORADO			89	353
CONNECTICUT				1,091
DELAWARE				55
FLORIDA			284	1,704
GEORGIA				125
HAWAII				
IDAHO				12
ILLINOIS			271	1,253
INDIANA			47	518
IOWA			23	371
KANSAS			61	197
KENTUCKY			92	449
LOUISIANA			188	836
MAINE				296
MARYLAND				378

* N/A for 1990

Applications Rejected and
Withdrawn by Applicants

	Small* Employer Group Certificates	Large* Employer Group Certificates	Association Group Certificates	Individual Policies
MASSACHUSETTS				94
MICHIGAN			238	564
MINNESOTA				190
MISSISSIPPI				74
MISSOURI			71	387
MONTANA				
NEBRASKA			45	199
NEVADA				36
NEW HAMPSHIRE				363
NEW JERSEY				
NEW MEXICO				74
NEW YORK				
NORTH CAROLINA				25
NORTH DAKOTA				144
OHIO			462	2,139
OKLAHOMA			72	401
OREGON				21
PENNSYLVANIA				93
RHODE ISLAND				
SOUTH CAROLINA				503

* N/A for 1990

Applications Rejected and
Withdrawn by Applicants

	Small* Employer Group Certificates	Large* Employer Group Certificates	Association Group Certificates	Individual Policies
SOUTH DAKOTA				234
TENNESSEE			134	696
TEXAS			101	1,726
UTAH				60
VERMONT				267
VIRGINIA			132	654
WASHINGTON				16
WEST VIRGINIA				54
WISCONSIN			164	386
WYOMING				5

* N/A for 1990

1990

Applications Received

	Small* Employer Group	Large* Employer Group	Association Group	Individual
MASSACHUSETTS				901
MICHIGAN			2,631	14,327
MINNESOTA				3,455
MISSISSIPPI				850
MISSOURI			703	5,664
MONTANA				
NEBRASKA			453	2,334
NEVADA				343
NEW HAMPSHIRE				5,518
NEW JERSEY				
NEW MEXICO				903
NEW YORK				
NORTH CAROLINA				2,223
NORTH DAKOTA				1,315
OHIO			3,817	25,480
OKLAHOMA			880	4,748
OREGON				202
PENNSYLVANIA				785
RHODE ISLAND				
SOUTH CAROLINA				6,493

* N/A for 1990

1990

Applications Received

	Small* Employer Group	Large* Employer Group	Association Group	Individual
SOUTH DAKOTA				2,732
TENNESSEE			1,805	9,834
TEXAS			1,484	24,853
UTAH				570
VERMONT				4,029
VIRGINIA			1,809	7,612
WASHINGTON				192
WEST VIRGINIA				1,053
WISCONSIN			1,929	8,393
WYOMING				437

* N/A for 1990

Request 2.b.3.

Cancellations/Non-Renewals

Nationwide

Year	Small Employer Group	Large Employer Group	Association Group	Individual
1990	827	6	526	22,281
1991	3269	16	16,339	71,992
1992	3456	6	46,550	64,384
1993	5541	66	62,524	55,755

Almost all (+/- 98%) of these were cancellations initiated by the insured.

Applications Rejected and Withdrawn by Applicants

	Small Employer Group Certificates	Large Employer Group Certificates	Association Group Certificates	Individual Policies
ALABAMA	5	0	130	6
ALASKA			66	0
ARIZONA	6	0	147	26
ARKANSAS	72	2	283	24
CALIFORNIA				
COLORADO	41	0	400	31
CONNECTICUT				1,265
DELAWARE			86	
FLORIDA			1,039	163
GEORGIA				3
HAWAII				
IDAHO				2
ILLINOIS	221	3	1,408	115
INDIANA	107	2	488	28
IOWA	8	0	274	14
KANSAS				2
KENTUCKY	154	0	454	42
LOUISIANA	566	0	934	146
MAINE				211
MARYLAND	3	0	322	

1993

Applications Rejected and Withdrawn by Applicants

	Small Employer Group Certificates	Large Employer Group Certificates	Association Group Certificates	Individual Policies
MASSACHUSETTS				183
MICHIGAN	126	0	550	9
MINNESOTA				161
MISSISSIPPI	12	0	196	12
MISSOURI	37	0	382	34
MONTANA				0
NEBRASKA	12	0	191	11
NEVADA				12
NEW HAMPSHIRE				177
NEW JERSEY				
NEW MEXICO				34
NEW YORK				
NORTH CAROLINA				4
NORTH DAKOTA				67
OHIO	399	0	1,524	183
OKLAHOMA	129	0	419	17
OREGON				2
PENNSYLVANIA				342
RHODE ISLAND				
SOUTH CAROLINA	214	0		640

[illegible]

Applications Rejected and Withdrawn by Applicants

	Small Employer Group Certificates	Large Employer Group Certificates	Association Group Certificates	Individual Policies
SOUTH DAKOTA				157
TENNESSEE	148	2	989	41
TEXAS	654	2	1,379	165
UTAH				20
VERMONT				
VIRGINIA	371	2	1,152	43
WASHINGTON				3
WEST VIRGINIA	104	0	273	12
WISCONSIN	339	0	943	
WYOMING				

1993

Applications Received

	Small Employer Group	Large Employer Group	Association Group	Individual
ALABAMA	30	0	713	1,120
ALASKA	84	0	382	183
ARIZONA	307	33	1,086	2,152
ARKANSAS			1,969	1,250
CALIFORNIA				
COLORADO	302	0	3,321	2,107
CONNECTICUT				20,383
DELAWARE			598	618
FLORIDA		37	6,230	6,427
GEORGIA	3			1,344
HAWAII				
IDAHO				37
ILLINOIS	1,491	113	11,186	12,221
INDIANA	804	101	3,924	4,259
IOWA	97	0	1,839	2,042
KANSAS	6	0		693
KENTUCKY	718	0	3,566	3,247
LOUISIANA	1,860	15	8,105	5,209
MAINE				2,688
MARYLAND	2	0	2,482	3,480

1993

Applications Received

	Small Employer Group	Large Employer Group	Association Group	Individual
MASSACHUSETTS				3,380
MICHIGAN	1,349	0	4,922	10,463
MINNESOTA				3,013
MISSISSIPPI	102	0	1,465	1,068
MISSOURI	418	86	2,532	3,409
MONTANA				
NEBRASKA	114	0	1,638	1,264
NEVADA				135
NEW HAMPSHIRE				3,993
NEW JERSEY				
NEW MEXICO	5	0		474
NEW YORK				
NORTH CAROLINA				1,981
NORTH DAKOTA				1,002
OHIO	1,360	0	9,505	12,091
OKLAHOMA	541	7	3,511	1,648
OREGON				203
PENNSYLVANIA				3,836
RHODE ISLAND				
SOUTH CAROLINA	721	0		9,478

1993

Applications Received

	Small Employer Group	Large Employer Group	Association Group	Individual
SOUTH DAKOTA	3	0		2,382
TENNESSEE	1,052	31	6,128	5,502
TEXAS	2,365	43	13,076	12,644
UTAH				336
VERMONT			46	
VIRGINIA	903	14	7,565	5,080
WASHINGTON				164
WEST VIRGINIA	466	0	1,471	1,441
WISCONSIN	1,003	0	6,238	7,783
WYOMING				301

Applications Rejected and Withdrawn by Applicants

	Small Employer Group Certificates	Large Employer Group Certificates	Association Group Certificates	Individual Policies
ALABAMA	2	0	106	9
ALASKA			52	2
ARIZONA	12	0	231	31
ARKANSAS	57	0	457	34
CALIFORNIA				
COLORADO	91	0	385	27
CONNECTICUT				1,398
DELAWARE			90	
FLORIDA			1,561	67
GEORGIA				3
HAWAII				
IDAHO				0
ILLINOIS	236	5	1,396	100
INDIANA	130	3	558	34
IOWA	10	0	288	36
KANSAS	9	0		9
KENTUCKY	419	0	525	60
LOUISIANA	256	0	906	143
MAINE				386
MARYLAND			351	

Applications Rejected and
Withdrawn by Applicants

	Small Employer Group Certificates	Large Employer Group Certificates	Association Group Certificates	Individual Policies
MASSACHUSETTS				66
MICHIGAN	168	0	736	4
MINNESOTA				205
MISSISSIPPI	46	0	163	25
MISSOURI	61	0	433	39
MONTANA				
NEBRASKA	8	0	243	19
NEVADA				41
NEW HAMPSHIRE				319
NEW JERSEY				
NEW MEXICO				94
NEW YORK				
NORTH CAROLINA				4
NORTH DAKOTA				96
OHIO	217	2	1,614	254
OKLAHOMA			382	27
OREGON				11
PENNSYLVANIA				242
RHODE ISLAND				
SOUTH CAROLINA	144	0		803

Applications Rejected and
Withdrawn by Applicants

	Small Employer Group Certificates	Large Employer Group Certificates	Association Group Certificates	Individual Policies
SOUTH DAKOTA				227
TENNESSEE	124	2	1,001	83
TEXAS	210	0	1,225	156
UTAH				38
VERMONT				239
VIRGINIA	262	1	1,173	66
WASHINGTON				3
WEST VIRGINIA	25	0	197	8
WISCONSIN	468	0	1,021	
WYOMING				

1992

Applications Received

	Small Employer Group	Large Employer Group	Association Group	Individual
ALABAMA	21	0	663	1,132
ALASKA			455	197
ARIZONA	80	0	1,556	1,887
ARKANSAS	238	23	3,129	1,940
CALIFORNIA	6			
COLORADO	262	0	4,179	4,940
CONNECTICUT				11,971
DELAWARE			699	527
FLORIDA		86	9,963	10,278
GEORGIA	11	0		1,892
HAWAII				
IDAHO				36
ILLINOIS	2,301	107	13,891	14,432
INDIANA	810	111	3,832	5,262
IOWA	116	0	2,379	2,218
KANSAS	58	0		850
KENTUCKY	1,072	0	4,452	3,895
LOUISIANA	1,118	2	8,561	6,908
MAINE				4,650
MARYLAND	11	0	3,094	3,496

1992

Applications Received

	Small Employer Group	Large Employer Group	Association Group	Individual
MASSACHUSETTS				1,023
MICHIGAN	1,477	3	7,215	13,015
MINNESOTA				4,099
MISSISSIPPI	234	0	1,205	1,002
MISSOURI	517	46	3,459	4,206
MONTANA				
NEBRASKA	131		2,027	1,454
NEVADA				220
NEW HAMPSHIRE				5,500
NEW JERSEY				
NEW MEXICO	8			483
NEW YORK				
NORTH CAROLINA				1,853
NORTH DAKOTA				1,361
OHIO	1,476	15	12,434	14,199
OKLAHOMA	436	17	3,738	1,902
OREGON				253
PENNSYLVANIA				2,951
RHODE ISLAND				
SOUTH CAROLINA	431	0		10,489

1992

Applications Received

	Small Employer Group	Large Employer Group	Association Group	Individual
SOUTH DAKOTA	99	0		3,365
TENNESSEE	1,155	152	8,783	6,958
TEXAS	1,567	45	15,740	14,200
UTAH				536
VERMONT				3,401
VIRGINIA	938	26	8,013	6,054
WASHINGTON				191
WEST VIRGINIA	311	0	1,352	1,253
WISCONSIN	839	0	7,734	7,857
WYOMING				340

Applications Rejected and Withdrawn by Applicants

	Small Employer Group Certificates	Large Employer Group Certificates	Association Group Certificates	Individual Policies
ALABAMA			66	23
ALASKA			50	2
ARIZONA			244	154
ARKANSAS	17	1	392	77
CALIFORNIA				
COLORADO	54	0	402	90
CONNECTICUT				1,250
DELAWARE			51	
FLORIDA			1,229	
GEORGIA	3	0		82
HAWAII				
IDAHO				7
ILLINOIS	189	2	1,242	367
INDIANA	76	0	649	147
IOWA	14	0	262	92
KANSAS	10	0	93	39
KENTUCKY	108	0	428	156
LOUISIANA	39	1	667	191
MAINE				360
MARYLAND			278	

Applications Rejected and
Withdrawn by Applicants

	Small Employer Group Certificates	Large Employer Group Certificates	Association Group Certificates	Individual Policies
MASSACHUSETTS				57
MICHIGAN	48	0	875	
MINNESOTA				162
MISSISSIPPI			34	115
MISSOURI	37	0	255	168
MONTANA				
NEBRASKA	12	0	188	54
NEVADA				46
NEW HAMPSHIRE				396
NEW JERSEY				
NEW MEXICO	5	0		91
NEW YORK				
NORTH CAROLINA				
NORTH DAKOTA				150
OHIO	177	10	1,644	539
OKLAHOMA	28	0	342	98
OREGON				16
PENNSYLVANIA				84
RHODE ISLAND				
SOUTH CAROLINA				464

Applications Rejected and Withdrawn by Applicants

	Small Employer Group Certificates	Large Employer Group Certificates	Association Group Certificates	Individual Policies
SOUTH DAKOTA				251
TENNESSEE	78	0	800	245
TEXAS	6	2	1,386	499
UTAH				69
VERMONT				327
VIRGINIA	84	0	827	132
WASHINGTON				4
WEST VIRGINIA	4	0	39	84
WISCONSIN	69	0	845	
WYOMING				

IN THE CIRCUIT COURT FOR THE SECOND JUDICIAL CIRCUIT
LAWRENCEVILLE, LAWRENCE COUNTY, ILLINOIS

GOLDEN RULE INSURANCE COMPANY,)
Plaintiff,)
vs.) Cause No. 91-MR-10
CLAUD A. KOCH,)
Defendant.)

GOLDEN RULE INSURANCE COMPANY'S
FIRST REQUEST FOR PRODUCTION OF DOCUMENTS
DIRECTED TO CLAUD A. KOCH

COMES NOW Golden Rule Insurance Company (herein "Golden Rule"), by its attorneys, and pursuant to Rules 214 and 12(c) of the Illinois Supreme Court Rules serves its First Request For Production of Documents requesting Claud A. Koch (herein "Koch") to produce the following documents to be inspected, copied or reproduced within 32 days of the date of the Certificate of Service hereof at the LAW OFFICES OF McGaughey & McGaughey, Ltd. or at a time and place agreed to by the parties:

1. Any and all Brochures, Conditional Receipts, and other documents received by Koch in the application process for the Golden Rule insurance policy.
   Golden Rule has copies of all requests in this item.

2. Any and all correspondence between Koch and Golden Rule whether sent to or received from Golden Rule.
   Golden Rule has copies of all correspondence to and from Claud A. Koch.

3. Any and all invoices, bills or receipts for medical expenses, whether paid or unpaid, from the date of Koch's application to Golden Rule for a policy to the present, i.e., from February 1, 1990 to September, 1992, including but not limited to evidence of payments made by other sources on claims that have been submitted to Golden Rule.

   Golden Rule has copies of all receipts, medical expenses, invoices and bills made in the claim.

4. Any and all insurance policies Koch had prior to the application date for the Golden Rule policy.

   Blue cross Blue Shield, Memphis, tennessee
   Golden Rule Insurance Company

5. Any and all insurance policies Koch presently has with any company.

   None

6. Copies of any and all prior applications for life, auto, homeowners, property and casualty, medical, health, hospital, accident or disability insurance which were submitted to any insurance company regardless of whether or not any insurance policy was issued on the application.

   Will takes two to three months to produce the requested information. Has nothing to do with medical insurance with Golden Ruls.

7. Any and all medical records pertaining to Koch.

   Will take 2-3 months to produce the requested info. Has nothing to do with medical insurance with Golden Rule.

8. Any and all correspondence between Koch and the Broker, Richard R. Spore, Jr.

   No correspondence between Koch and Richard Spore.

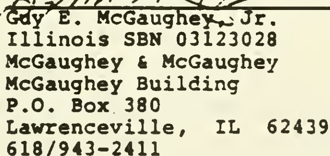
9. Any and all checks from Koch to premiums paid on the Golden Rule polic for medical expenses on any policy of i
All checks given to Golden Rule is being Golden Rule's bank account.

10. Any and all checks from Koch to any insur for premiums paid on any insurance po presently has in effect or was in effect w years prior to the application date for his Golde policy, i.e. February 1, 1980.

None

Respectfully submitted,

Golden Rule Insurance Company



Guy E. McGaughey, Jr.
Illinois SBN 03123028
McGaughey & McGaughey
McGaughey Building
P.O. Box 380
Lawrenceville, IL 62439
618/943-2411

CERTIFICATE OF SERVICE

The undersigned attorney certifies that a copy of this document was mailed to all counsel listed below, in an envelope properly addressed as follows:

Stephen J. Hough
Croegaert, Clark & Hough, Ltd.
305 East Main Street
Olney, IL 62450

IN THE CIRCUIT COURT FOR THE SECOND JUDICIAL CIRCUIT
LAWRENCEVILLE, LAWRENCE COUNTY, ILLINOIS

GOLDEN RULE INSURANCE COMPANY,)
Plaintiff,)
vs.) Cause No. 91-MR-10
CLAUD A. KOCH,)
Defendant.)

GOLDEN RULE INSURANCE COMPANY'S FIRST SET OF INTERROGATORIES TO CLAUD A. KOCH

Comes now Golden Rule Insurance Company (herein "Golden Rule"), by its attorneys, and propounds the following Interrogatories to be answered fully and under oath by Claud A. Koch (herein "Koch"), pursuant to Rules 213 and 12(c) of the Illinois Supreme Court Rules within 32 days after the mailing date on the Certificate of Service upon attorneys for the person to answer these Interrogatories.

INSTRUCTIONS

Definitions and Instructions: As used in this Request, the definitions and instructions listed below apply:

1. The term "Golden Rule policy", as used herein, refers to Golden Rule's Insurance policy, Policy No. 053120504, effective February 5, 1990 for injuries and February 19, 1990 for illnesses, issued to Claud A. Koch.

2. The terms "you" and "yours", as used herein, refer to Defendant herein, as well as to each and every person who has suffered an illness or injury which Plaintiff has declined to

cover under the policy. "You" and "yours" also includes your agents, attorneys, affiliates and spouse.

3. The term "application date", as used herein, refers to the date on which the application for the "Golden Rule policy" was signed by the applicant(s).

4. "Document" is defined to include without limitation all originals and nonidentical copies of accounts, acknowledgements, advertisements, affidavits, agreement, analyses, applications for patents, appointment books, articles, assignments, balance sheets, bills, bills of lading, bills of sale, books, brochures, business cards, calculations, calendars, catalogues, charts, circulars, client lists, clippings, computer cards, computer readable disks, computer printouts, computer programs, computer tapes, consultant lists, consultation reports, contracts, corporate minutes and minute books, customer lists, correspondence, data compilations, deposition transcripts, diagrams, diaries, descriptions, drafts, drawings, employment records, evaluations, files, film, financial statements, forms, formulas, franchises, graphs, histories, income statements, indexes, instructions, insurance records, insurance reports, invoices, job assignments, job descriptions, journals, letters, licenses, lists, literature, log books, looseleaf binders, magazines, mailgrams, manuals, maps memoranda, messages, microfiche, microfilm, minutes, models, motions pictures, news clippings, newsletters, newspapers, notebooks, notes, notices, opinions, orders, organizational charts, pamphlets, papers, patents, periodicals, personnel records, phonorecords, photographic negatives, photographs,

pleadings, pocket calerdars, press releases, prints, procedures, prototypes, publications, purchase orders, receipts, records, regulations, reports, rules, samples, schedules, searches, shipping orders, shop drawings, slides, specifications, statements, statements of account, statements of assets and liabilities, statistics, studies, summaries, surveys, tangible things, tape recordings, tax returns, telegrams, telephone lists, telephone logs, telexes, test results, trade letters, transcripts, travel vouchers, treatises, trip report, vouchers, work orders, work sheets and writings.

5. "Identify", when used in reference to a natural person or individual, means to state his or her full name, present or last known address and phone number.

6. "Identify", when used in reference to a person other than a natural person or individual, means to state its full name, present or last known address and phone number, and the name of the officer or other person who has best knowledge of the matter with respect to which the entity has been identified.

7. "Identify", when used in reference to a document, means to state its title, type (e.g., letter, memorandum, etc.); date; author(s) or originator(s); addressee(s) or recipient(s); subject matter; any file numbers which may be used in locating same; the name, present or last known address and phone number of all persons having possession, custody or control of same; and its disposition, if no one presently has possession, custody or control of same.

8. The terms "relate" or "relating" mean referring or pertaining to in any logical or factual way.

9. Reference to any person, corporation, partnership, venture or other entity shall include references to such persons officers, directors, agents, attorneys, parents, subsidiaries, predecessors and shareholders. The singular shall also include the plural and masculine pronouns shall also include the feminine and the neuter, as the context requires.

10. If any information is to be withheld for any reason, identify the document containing the information and state the specific legal basis for each such withholding.

11. All information requested in these Interrogatories is to be divulged if it is in your possession and control, or in the possession or control of your attorneys, investigators, agents, employees or other representatives.

12. Whenever the word "you" is set forth in the Interrogatories herein, it shall cover all those persons who are covered by the Golden Rule policy such as spouses, children or other covered persons.

13. All answers must be made separately, fully, and under oath. An incomplete or evasive answer is a failure to answer for which Defendant will seek sanctions.

14. You are under a continuing duty to supplement reasonably your responses with respect to any matter which is within the scope of these Interrogatories.

INTERROGATORIES

INTERROGATORY No. 1: Please identify yourself fully giving your full name and any aliases or other names you have been known by, Social Security number, date of birth, present age and present resident address and telephone number.

ANSWER:

Name (Alias)	S.S. No.	Birth Date	Present Age	Residence Address	Phone No.

INTERROGATORY NO. 2: Identify each doctor, including name, address and telephone number, that you have seen during the 10 years preceding the application date of the "Golden Rule policy" up until the present time, i.e., February 1, 1980 to September, 1992;

(A) For each doctor identified give the approximate dates and reason for each visit.

(B) "Doctor" includes physicians, surgeons, chiropractors, psychiatrists, psychologists, therapists, osteopaths, social workers.

ANSWER:

Name, address, telephone number	Approximate dates	Reasons Seen	Prescriptions
(1)			
(2)			
(3)			

(4)

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

(13)

(14)

(15)

<u>INTERROGATORY NO. 3:</u> Identify any drugs, prescriptions or medications that you have taken during the 10 years preceding the application date of the policy and up until the present date,

i.e., from February 1, 1980 tc September, 1992, including the name of the drug prescribed, approximate date, name of issuing pharmacy, name of doctor prescribing.

ANSWER:

Drug(s) prescribed	Date of prescription	Name & address of pharmacy	Doctor prescribing
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			
(7)			
(8)			
(9)			
(10)			
(11)			

(12)

(13)

(14)

(15)

INTERROGATORY NO. 4: Describe each hospitalization, whether inpatient, outpatient or emergency room, which you experienced during the 10 years preceding the application date of the policy, up to the present, i.e., February 1, 1980 to September, 1992, including the name and address of the hospital, rehabilitation center, hospice, treatment facility, therapy facility, the inclusive dates you stayed there, the reason or reasons for which you went there and the name and address of each doctor (as identified in Interrogatory No. 2B) who saw you during your stay.

ANSWER:

Name and address of Hospital	Inclusive Dates	Reason for Stay	Name/Address of Doctors Who Saw You
(1)			
(2)			
(3)			
(4)			

(5)

(6)

(7)

(8)

(9)

(10)

(11)

(12)

(13)

(14)

(15)

<u>INTERROGATORY NO. 5:</u> Itemize all incurred medical bills which are the subject of this litigation. For each medical bill state the name and address of the medical provider or doctor (as defined in Interrogatory 2B), date of service, amount of bill, who paid, unpaid balance as of now.

ANSWER:

Name Medical Provider	Date of Service	Amt of Medical Bill	Amt Paid	Who Paid	Unpaid Balance
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					
(9)					
(10)					
(11)					
(12)					

(13)

(14)

(15)

(16)

(17)

(18)

(19)

(20)

(21)

(22)

(23)

(24)

(25)

<u>INTERROGATORY NO. 6:</u> Please list all Exhibits you intend to introduce in evidence at trial or hearing.

<u>ANSWER:</u>

Description Document	Date Document	Subject Matter
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		
(9)		
(10)		
(11)		

(12)

(13)

(14)

(15)

(16)

(17)

(18)

(19)

(20)

(21)

(22)

(23)

(24)

(25)

INTERROGATORY NO. 7: Describe each sickness, illness, disease, injury, medical condition, or medical symptoms which you have had during the 10 years immediately preceding your application date, to the present time from February 1, 1980 to September 1992, and for which you sought or considered seeking any medical or other testing, treatment, advice, or diagnosis including the nature of the sickness, illness, disease, injury, medical condition, medical symptom, the name, address and telephone number of each doctor or facility from whom you received medical testing, treatment, advice or diagnosis and the dates such testing treatment, advice or diagnosis were received.

ANSWER:

Nature of sickness, illness, disease, injury, condition, symptom	Approx. date of onset	Testing, treating, advising, diagnosing doctor or facility	Approx. dates of treatment or advice
(1)			
(2)			
(3)			
(4)			
(5)			
(6)			

(7)

(8)

(9)

(10)

(11)

(12)

(13)

(14)

(15)

INTERROGATORY NO. 8: As to your application for Golden Rule Insurance please answer the following questions:

(a) the date and place the application was completed;

(b) the persons present when the application was taken, completed and/or signed;

(c) were each of the questions which appear on the application asked of you or read by you;

(d) are the answers written on the application your answers;

(e) did you read the application before you signed it.

ANSWER:

(a)

(b)

(c)

(d)

(e)

INTERROGATORY NO. 9: Please answer the following questions as to the individual, if any, to whom you gave answers in the completion of your application for Insurance:

(a) name of individual, address and telephone number;

(b) did he or she present and/or discuss with you other insurance companies providing insurance for the type of insurance you were seeking;

(c) If you contend you told any person identified above any fact regarding your health, medical history or physical or mental state of being which does not appear on the

application, then for each fact state:

(1) name of the person whom you told;

(2) the date which you told such person;

(3) in detail each fact you relayed to such person.

ANSWER:

(a)

(b)

(C-1)

(C-2)

(C-3)

INTERROGATORY NO. 10: If you contend that any representative of Golden Rule made any promises or representations regarding the nature or extent of coverage to be provided under the policy or that any particular claim would be paid, then for each such promise or representation state:

(a) the name of the person making such promise or representation;

(b) the date and place it was made;

(c) the name of the person to whom it was made;

(d) what was said to you and what did you say.

ANSWER:

(a)

(b)

(c)

(d)

INTERROGATORY NO. 11: Please describe each and every insurance policy in effect, including the name of the insurance company, its address, policy number, dates coverage was/is in effect, the type of coverage, whether you made claims or not and were any claims paid by any insurance company for life, auto, homeowners, property and casualty, health, hospital, accident and/or disability insurance of any kind, during the 10 years immediately preceding your application date, up to the present time from February 1, 1980 to September, 1992.

ANSWER:

Name &	Policy	Date	Type	You made	Claims

Address of insurer	No.	of Cov.	of Cov.	claims yes/no	paid by whom
(1)					
(2)					
(3)					
(4)					
(5)					
(6)					
(7)					
(8)					

INTERROGATORY NO. 12: If, when you applied for insurance with Golden Rule, you intended for the Golden Rule policy to replace any existing policy, please describe each policy that was to be replaced including the name and address of the prior insurance company, the number of the policy, the date of expiration of the policy, the type of coverage and if the prior policy contained the privilege to convert to another policy with that company.

ANSWER:

Name & address of Insurance Co.	Policy No.	Expiration date	Type of Cov.	Conversion Privilege

(1)

(2)

(3)

(4)

(5)

(6)

<u>INTERROGATORY NO. 13:</u> Identify all brokers and/or agents, whether independent or captive, associated with any <u>insurance company of any kind</u>, other than the broker for Golden Rule

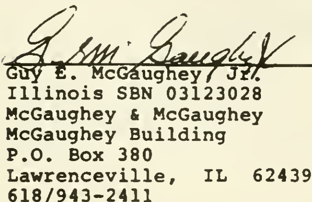
Insurance Company, with whom you have dealt with or have done business with during the past ten (10) years.

ANSWER:

	Name	Address
(1)		
(2)		
(3)		
(4)		
(5)		
(6)		
(7)		
(8)		

Respectfully submitted,

Golden Rule Insurance Company



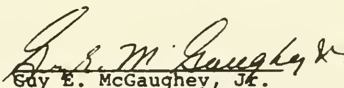
Guy E. McGaughey, Jr.
Illinois SBN 03123028
McGaughey & McGaughey
McGaughey Building
P.O. Box 380
Lawrenceville, IL 62439
618/943-2411

CERTIFICATE OF SERVICE

The undersigned attorney certifies that a copy of this document was mailed to all counsel listed below, in an envelope properly addressed as follows:

Stephen J. Hough
Croegaert, Clark & Hough, Ltd.
305 East Main Street
Olney, IL 62450

with first class postage prepaid addressed to his business address from the U.S. Post Office on this the 28th day of September, 1992.



Guy E. McGaughey, Jr.

with first class postage prepaid addressed to his business address from the U.S. Post Office on this the 7th day of September, 1992.

Guy E. McGaughey, Jr.

IN THE CIRCUIT COURT FOR THE SECOND JUDICIAL CIRCUIT
LAWRENCEVILLE, LAWRENCE COUNTY, ILLINOIS

GOLDEN RULE INSURANCE COMPANY,	)	
Plaintiff,	)	
	)	Cause No. 91-MR-10
vs.	)	
	)	
CLAUD A. KOCH,	)	
	)	
Defendant.	)	

GOLDEN RULE INSURANCE COMPANY'S FIRST SET OF REQUESTS FOR ADMISSION TO CLAUD A. KOCH

Comes now Golden Rule Insurance Company (herein "Golden Rule"), by its attorneys, and pursuant to Rules 216 and 12(c) of the Illinois Supreme Court Rules, serves its First Set of Requests for Admission to be admitted or denied by Claud A. Koch (herein "Koch") within 32 days after the Certificate of Service hereof.

REQUEST FOR ADMISSION NO. 1: On February 1, 1990, Koch signed an application for health insurance with Golden Rule Insurance Company.

RESPONSE:

Yes

REQUEST FOR ADMISSION NO. 2: A true and accurate copy of Koch's application for Golden Rule insurance is attached hereto as Exhibit A-1 and A-2.

RESPONSE:

No

REQUEST FOR ADMISSION NO. 3: Koch personally completed the application for insurance.

RESPONSE:

Mostly

REQUEST FOR ADMISSION NO. 4: On the back side of the application, Koch signed his name underneath a statement, which states, inter alia:

> "I have personally completed this application and I represent that the answers and statements on this application are true, complete and correctly recorded to the best of my knowledge.
>
> I UNDERSTAND AND AGREE that: (1) the statements and answers given in this application, and in any supplements or amendments to it, will form the basis of, and be made a part of, any policy which may be issued; (2) any incorrect or incomplete information on this application may result in loss of coverage or claim denial; (3) in accordance with the conditional receipt given to me, this application and the payment of the initial premium does not give me immediate coverage; (4) the agent or broker: is only authorized to submit the application and initial premium; may not change any

> application, policy, or receipt; and cannot waive any right or requirement; and (5) coverage for illness does not begin until the 15th day after a person becomes insured. for injury. I have received the Notice of Information Practices."

RESPONSE:

Received policy from Golden Rule Insurance Company in the latter part of May, 1990. Had no knowledge of exclusions or coverages until that time. Golden Rule had obtained X-rays, full investigations of different conditions.

REQUEST FOR ADMISSION NO. 5: On the front page of the policy received by Koch, there was a label which contained the following statement:

> "Check the Attached Application: Please read the copy of the application attached to your policy. If it is not complete or has an error, please let us know immediately. An incorrect application may cause your coverage under the policy to be voided or a claim to be reduced or denied.
>
> Pre-Existing Conditions: A person is not covered for any illness until the 15th day after he or she became a covered person under the policy. A health condition which exists on or before the date that a person would otherwise become insured for that condition is not covered during the first twelve months of coverage, unless it was fully disclosed to us prior to coverage. See the Pre-Existing Conditions clause for details."

RESPONSE:

No pre-existing condition existed. Letters from seven doctors forwarded to Golden Rule when policy was canceled. Every letter stated no pre-existing condition.

REQUEST FOR ADMISSION NO. 6: On the front page of the policy issued to Koch, the policy provides:

> "20-Day Right to Examine and Return This Policy. Please

read this policy. If you are not satisfied, you may return the policy within 20 days after you received it. Mail or deliver it to us or to your agent. Any premium paid will be refunded. This policy will then be void from its start.

Check the attached application. If it is not complete or has an error, please let us know. An incorrect application may cause your policy to be voided, or a claim to be reduced or denied."

RESPONSE:

Policy was not delivered until the latter part of May, 1990. All exclusions listed on the policy were not known by defendant. In fact, we did not even know if we had insurance until that date. Policy was retained by the agent and not delivered until that time.

REQUEST FOR ADMISSION NO. 7: Koch read the policy upon receipt.

RESPONSE:

Read the policy exclusions. Other information included in policy is too legalistic for a layman to comprehend.

REQUEST FOR ADMISSION NO. 8: Koch read the "Pre-Existing Conditions Limitation" section (page 15) of the policy.

RESPONSE:

Yes, but there was no pre-existing condition existing at that time.

REQUEST FOR ADMISSION NO. 9: Koch read the "Contract" section (page 17) of the policy.

RESPONSE:

Yes, including the exclusions.

REQUEST FOR ADMISSION NO. 10: Koch did not notify Golden Rule that any of the information on the application was incorrect or incomplete.

RESPONSE:

Did not feel it was necessary to notify Golden Rule as there was no pre-existing condition.

REQUEST FOR ADMISSION NO. 11: Koch responded "No" to question 15(a) of the application, to wit:

> "Has any person named in #1, within the last 10 years, had any indication, diagnosis, or treatment of: (a) any disorder of the heart or circulatory system, including high blood pressure, amenia, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis, or stroke?"

RESPONSE:

True--there had been no pre-existing condition, no irregular heartbeat or other problems listed in this request.

REQUEST FOR ADMISSION NO. 12: Koch knew the representation made on the application in response to question 15(a) was false at the time it was made.

RESPONSE:

Not true

REQUEST FOR ADMISSION NO. 13: In November, 1986, a chest X-ray performed on Koch revealed an unusual rim-like area of calcification projecting from the right cardiac border.

RESPONSE:

The unusual rim-like area of calcification projecting from the right cardiac border is a scar tissue which was present when entered US military service, December 1946.

REQUEST FOR ADMISSION NO. 14: Koch responded "No" to question 15(b) of the application, to-wit:

> "Has any person named in #1, within the last 10 years, had any indication, diagnosis or treatment of: (b) cancer, tumor, cyst, polyp, or growth of any kind, or skin disorder or disease?"

RESPONSE:

Discussed removal of polyp with Agent Spore. This was done at the time of treatment of automobile accident in 1987.

REQUEST FOR ADMISSION NO. 15: Koch knew the representation made on the application in response to question 15(b) was false at the time it was made.

RESPONSE:

Not true

REQUEST FOR ADMISSION NO. 16: In August, 1987, Koch was advised of a mucous retaining cyst in his left maxillary sinus.

RESPONSE:

Not true

REQUEST FOR ADMISSION NO. 17: On July, 1988, Koch was advised that sigmoid polyps was discovered.

RESPONSE:

True, Discussed with Agent Spore

REQUEST FOR ADMISSION NO. 18: Koch responded "No" to question 15(d) of the application, to-wit:

> "Has any person named in #1, within the last 10 years, had any indication, diagnosis, or treatment of: (d) any disorders of the nervous system (including epilepsy, convulsions, headaches, paralysis, or mental illness); nervousness, emotional or behavioral disorders; or consulted with a psychologist or psychiatrist?"

RESPONSE:

One answer--no

REQUEST FOR ADMISSION NO. 19: Koch knew the representation made on the application in response to question 15(d) was false at the time it was made.

RESPONSE:

No

REQUEST FOR ADMISSION NO. 20: In November, 1986, Koch was hospitalized for psychogenic amnesia.

RESPONSE:

No

REQUEST FOR ADMISSION NO. 21: Koch responsed "No" to question 15(e) of the application, to-wit:

> "Has any person named in #1, within the last 10 years, had any indication, diagnosis, or treatment of: (e) any disorder of the digestive system (including ulcer, gastritis, intestinal disorders, colitis, gall stone, hemorrhoids, bloody stools, or hernia); or disorder of the pancreas, liver, spleen, or gallbladder?"

RESPONSE:

No

REQUEST FOR ADMISSION NO. 22: Koch knew the representation made on the application in response to question 15(e) was false at the time it was made.

RESPONSE:

No

REQUEST FOR ADMISSION NO. 23: In April, 1988, Koch advised Dr. Kaplan he had incontinence of the bowels.

RESPONSE:

Yes --Result of automobile accident and was excluded on the policy by Golden Rule.

REQUEST FOR ADMISSION NO. 24: Koch responded "No" to question 15(h) of the application, to-wit:

> "Has any person named in #1, within the last 10 years, had any indication, diagnosis or treatment of: (h) any disorder of the lungs or respiratory system, including allergies, asthma, bronchitis, tuberculosis, or emphysema?"

RESPONSE:

No

REQUEST FOR ADMISSION NO. 25: Koch knew the representation made on the application in response to question 15(h) was false at the time it was made.

RESPONSE:

No

REQUEST FOR ADMISSION NO. 26: In August, 1988, Dr. Wilson advised Koch he suffered chronic bronchitis with sencbrachia syndrome.

RESPONSE:

No

REQUEST FOR ADMISSION NO. 27: Koch responded "No" to question 15(j) of the application, to-wit:

> "Has any person named in #1, within the last 10 years, had any indication, diagnosis, or treatment of: (j) any disorder of the male or female reproduction organs, prostrate problems, irregular menstruation, abnormal pap test, or pregnancy complications, including Cesarean Section delivery?"

RESPONSE:

Result of automobile accident which was excluded in policy by Golden Rule.

REQUEST FOR ADMISSION NO. 28: Koch knew the representation made on the application in response to question 15(j) was false at the time it was made.

RESPONSE:

Listed above in No. 27

REQUEST FOR ADMISSION NO. 29: In April, 1988, Koch complained to Dr. Kaplan that he suffered impotency.

RESPONSE:

Result of automobile accident.

REQUEST FOR ADMISSION NO. 30: Koch was referred to, and later was treated by Dr. Pearson for impotency.

RESPONSE:

Result of automobile accident

REQUEST FOR ADMISSION NO. 31: Koch responsed "No" to question 15(k) of the application, to-wit:

> "Has any person named in #1, within the last 10 years, had any indication, diagnosis or treatment of: (k) any disorder of the eyes, ears, nose or throat, including impaired sight or hearing, earaches, or tonsillitis?"

RESPONSE:

Wear glasses. No other problems in this question.

REQUEST FOR ADMISSION NO. 32: Koch knew the representation made on the application in response to question 15(k) was false at the time it was made.

RESPONSE:

Same answer as above in No. 31

REQUEST FOR ADMISSION NO. 33: In April, 1988, Koch complained of pain in the left ear, as well as the upper parts of the body.

RESPONSE:

Result of automobile accident November, 1987, which was excluded by Golden Rule in all areas affected by the accident.

REQUEST FOR ADMISSION NO. 34: Koch made the false and misleading representations with the intent to defraud Golden Rule.

RESPONSE:

Untrue. There was no misleading representation or intent to defraud Golden Rule of anything.

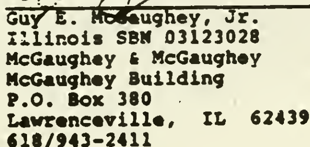
REQUEST FOR ADMISSION NO. 35: The false and misleading information provided by Koch to Golden Rule increased the risk to be assumed by Golden Rule when it issued policy #053120504.

RESPONSE:

Golden Rule made a full investigation of all medical information and had the right to refuse policy to defendant. The cancellation of this policy falls into the same category of the hundreds of other policies canceled by Golden Rule.

Respectfully submitted,

Golden Rule Insurance Company



Guy E. McGaughey, Jr.
Illinois SBN 03123028
McGaughey & McGaughey
McGaughey Building
P.O. Box 380
Lawrenceville, IL 62439
618/943-2411

CERTIFICATE OF SERVICE

The undersigned attorney certifies that a copy of this document was mailed to all counsel listed below, in an envelope properly addressed as follows:

Stephen J. Hough
Croegaert, Clark & Hough, Ltd.
305 East Main Street
Olney, IL 62450

with first class postage prepaid addressed to his business address from the U.S. Post Office on this the 15th day of September, 1992.

Guy E. McGaughey, Jr.

APPLICATION FOR INSURANCE

GOLDEN RULE INSURANCE COMPANY - LAWRENCEVILLE, ILLINOIS 62439

1. Persons to be covered (First name, middle initial, last name)

	Name	Status	Age	Birthdate	Sex	Height	Weight
a.) Proposed Insured (You)	CLAUD A. Koch	☒ Married ☐ Single	60	12/2/29	M	5'10"	185
b.) Spouse (if to be covered)	BONNIE S. KOLWYCK Koch		53	10/7/36	F	5'7	135
Dependent Children (if to be covered) (Use second app for more space) c.)	NONE						
d.)							
e.)							
f.)							

2. Home Address (Street No., City, State, ZIP Code, County, Phone No.): 2937 Johnson RD, GERMANTOWN, TN. 38139 SHELBY 901 754-5940

3. Person who will pay the premium (If not You) (Give full name, address and relation to You): —0— PAC FROM SPOUSE BANK ACCOUNT

4. Your Occupation (Describe Duties): SELF EMPLOYED — Your Employer: SALES — Name: SELF — Phone No. Area (901) 754-5940

Date Hired: 30 YRS — Prior Employment (If within 2 years): 0

5. Total Income for all persons in #1: $ 75000.

6. Your Beneficiary (Give full name, relation to you and age) (You will be the beneficiary for all other persons.): BONNIE S. KOLWYCK Koch

7. POLICY INFORMATION

a. Plan Applied For: Inflation Guard Major Medical

b. Rate Area: IV

c. Plan Data — Deductible Amount: ☐ $250 ☐ $500 ☒ $1,000

d. Optional Pregnancy Benefits: ☒ Not Selected ☐ $500 Maximum Benefit ☐ $750 Maximum Benefit ☐ $1,000 Maximum Benefit

e. Premium Mode: ☐ Quarterly ☒ Monthly Pre-Auth. Charge (Submit Pre-Auth. Charge form with application)

f. Premium Amounts from Rate Book. Check Policy Benefits Applied For:
☐ Basic Benefits $ 226.08
☐ Optional Pregnancy $ -0-

g. Total Premium for Mode Chosen $ 226.08

Note: The correct premium rate must be verified by Golden Rule. It will be stated in the Policy.

8. Special Instructions: POLICY EFFECTIVE 2-5-90

9. Are any persons named in #1 covered by, or has application been made for, any type of life or medical insurance? If yes, list below. "Medical insurance" includes health service plans, such as Blue Cross/Blue Shield, HMOs or similar plans, as well as expense and indemnity policies, including specified disease policies, such as those for cancer. Answer "yes" if any person has a current Medicare or Medicaid eligibility card. Yes ☐ No ☒

Persons (Line #s)	Company Name	Life Insurance Plan Type	Life Insurance Face Amt.	Medical Insurance Plan Type	Deductible	Max. Benefits
	JUST CAME OFF GROUP INSURANCE					

10. Will the plan applied for replace or change any existing insurance or annuities? If yes, give: Yes ☐ No ☒
Company Name: Termination Date: / / Policy Number: Describe Coverage:

If any answer to questions 11 - 19 is yes, provide all details in item #21.

11. Has any person named in #1 ever applied for, or been covered by, Golden Rule? Yes ☐ No ☒
If yes, state the Policy Number ____________ and Primary Insured ____________

12. Has any life or health insurance application or policy on any person named in #1 ever been voided, declined, cancelled, postponed, or modified as to plan, amount or rate? Yes ☐ No ☒

13. Has any person named in #1 ever taken part in, or, in the next 2 years, plan to take part in:
a. flying as a pilot or crew member of any type of aircraft? Yes ☐ No ☒
b. skydiving, parachuting, hang gliding, underwater diving, auto racing, or driving any type of motorcycle? Yes ☐ No ☒
If yes, specify which activities here:

14. Has any person named in #1:
a. smoked cigarettes within the past 12 months? Yes ☐ No ☒
b. experienced a weight gain or loss of 15 pounds or more in the last 12 months? Yes ☐ No ☒

GRI-AP-9.1

(Continued on back side)

6714-1089

15. Has any person named in #1 within the last 10 years had any indication, diagnosis or treatment of:
a. any disorder of the heart or circulatory system, including high blood pressure, heart attack, heart murmur, chest pain, irregular heartbeat, varicose veins, phlebitis or stroke? ---------- ☐ ☒
b. cancer, tumor, cyst, polyp or growth of any kind, or skin disorder or disease? ---------- ☐ ☒
c. any blood abnormalities, immune system deficiencies, or sexually transmitted diseases? ---------- ☐ ☒
d. any disorders of the nervous system (including epilepsy, convulsions, headaches, paralysis, or mental illness), nervousness, emotional or behavioral disorders; or consulted with a psychologist or psychiatrist? ---------- ☐ ☒
e. any disorder of the digestive system (including ulcer, gastritis, intestinal disorders, colitis, gall stone, hemorrhoids, bloody stools, or hernia); or disorder of the pancreas, liver, spleen, or gallbladder? ---------- ☐ ☒
f. diabetes, sugar in the urine, or disorder of the thyroid, (breast) or other glands? ---------- Bonnie ---------- ☒ ☐
g. any disorder of the muscular or skeletal systems, including arthritis, gout, rheumatism, or any jaw, knee, back, or spine disorders? ---------- ☐ ☒
h. any disorder of the lungs or respiratory system, including allergies, asthma, bronchitis, tuberculosis, or emphysema? ---------- ☐ ☒
i. any disorder of the genito-urinary system, including kidney disorder, kidney stones, cystitis, prostatitis, bladder infections, or blood in the urine? ---------- ☐ ☒
j. any disorder of the male or female reproductive organs, prostate problems, irregular menstruation, abnormal pap test, or pregnancy complications, including Cesarean Section delivery? ---------- ☐ ☒
k. any disorder of the eyes, ears, nose or throat, including impaired sight or hearing, earaches, or tonsillitis? ---------- ☐ ☒

16. **Has any person named in #1, within the past 5 years:** Yes No
a. had any indication, diagnosis, or treatment of alcohol or drug dependency, abuse, or reaction? ---------- ☐ ☒
b. used any drug not prescribed, such as opiates, stimulants, depressants, and/or hallucinogens? ---------- ☐ ☒

17. **Is any person named in #1 currently:**
a. taking medication or receiving medical treatment of any kind? ---------- ☐ ☒
b. a user of alcoholic beverages in excess of 14 drinks per week? If yes, show who and how many drinks per week in #21 below. ☐ ☒
(one drink equals: 12 oz. of beer; 4 oz. of wine; 1 oz. of hard liquor)

18. **Is any family member (whether or not named in this application) pregnant? If yes, show expected delivery date in #21.** ☐ ☒

19. **Has any person named in #1, within the last 10 years, been hospital confined, had surgery, or discussed surgery with a doctor?** Yes ☒ No ☐

20. **What are the names of all doctors consulted in the past 5 years by persons named on this application? List the doctors' names and give full details in #21 below.**

21. **IMPORTANT: Give complete details of any "Yes" answers to questions 11 thru 19 and respond to question 20.**

Question Number	Person (Line #)	Symptoms or Condition	Dates	Treatment, Advice Given, Results, and other details	Name and Address of Doctors and Hospitals
F	1B		3-89	SMALL CYST REMOVED FROM LEFT	
				BREAST	EUGENE NOBLES-MD
					920 MADISON
					MEMPHIS TN
20	1A		7-87	PNEUMONIA-HOSP 15 DAYS	
				COMPLETE RECOVERY	DR. MICHAEL WILLIAMS
					20 SO DUDLEY
					MEMPHIS TN

(If more space is needed, attach a supplement and sign it. Check this box ☒ if anything is attached.)

22. Requested Effective Date: (See Conditional Receipt)

I have personally completed this application and I represent that the answers and statements on this application are true, complete, and correctly recorded to the best of my knowledge.

I UNDERSTAND AND AGREE that: (1) the statements and answers given in this application, and in any supplements or amendments to it, will form the basis of, and be made a part of, any policy which may be issued; (2) any incorrect or incomplete information on this application may result in loss of coverage or claim denial; (3) in accordance with the conditional receipt given to me, this application and the payment of the initial premium does not give me immediate coverage; (4) the agent or broker: is only authorized to submit the application and initial premium; may not change any application, policy, or receipt; and cannot waive any right or requirement; and (5) coverage for illness does not begin until the 15th day after a person becomes insured for injury. I have received the Notice of Information Practices.

Signed 2/1 1990 at GERMANTOWN TN — Date, City, State — x Claud A. Koch — Signature of Proposed Insured (You)

x ______ Signature of Parent/Guardian (if you are a minor) — x Bonnie K. Koch — Signature of Spouse (if to be covered)

FEB 7 1990

REVIEW THE COMPLETED APPLICATION BEFORE SIGNING

G21-AP-9 1

For Agent/Broker

Each question on this application was completed by the applicant(s). I have personally witnessed the reading, completion, and signing of this application.

I have collected the initial premium and given the conditional receipt.

Unless I have given a different response below, the response shown for question 10 on this application reflects my understanding and response to the question "Will the plan applied for replace or change any existing insurance or annuities?" ☐ Yes ☒ No

Richard R. Spence Jr. — Signature of Licensed Agent or Broker

RICHARD R. SPENCE, JR. + ASSOCIATES, INC. — Print Full Name

6208807978 — Agent/Broker #

Golden Rule will act on this application as quickly as possible. The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for any further delay.

6774-1039

"Exhibit A-2"

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

No application will be accepted if received by Golden Rule at its Home Office or Executive Office more than 15 days after the date signed.

MISCELLANEOUS REMEDIES CASE NUMBER LIST

FRANK THOMPSON CO

CASE NUMBER	DATE FILED MO	DAY	FIRST NAMED PLAINTIFF	FIRST NAMED DEFENDANT	PERMANENT RECORD REEL NUMBER
6-MR-15	11	17	The City of Lawrenceville, Illinois	Janette M. Malone	
-MR-16	12	1	Golden Rule Insurance Company	James L. Coulter	
-MR-17	12	17	Golden Rule Insurance Company	Robert C. Kebel	
-MR-18	12	17	Golden Rule Insurance Company	Nelson F. Orbe	
-MR-19	12	18	Frederick H. Johnson	Eddie Ryan, Sheriff of Lawrence County	
86-MR-20	12	18	The United Methodist Village	Clarence H. Cornett	
-MR-21	12	23	Golden Rule Insurance Company	Marilyn E. Ragsdale	
~~MR~~ 1987					
-MR-1	1	20	In the Matter of Henry Wightman		
-MR-2	1	27	Golden Rule Insurance Company	Willis R. Wright, etal	
-MR-3	1	28	Golden Rule Insurance Company	John F. Flynn	
-MR-4	3	13	Golden Rule Insurance Company	Edward J. Burke, etal	
-MR-5	4	6	Golden Rule Insurance Company	Steven H. Urish	
87-MR-6	4	14	Golden Rule Insurance Company	Craig A. Brewer	
-MR-7	4	24	Jeremy Lee Parrell, a minor, and	Jason Lee Parrell, a minor, by Maria Parrell their mother and next friend	
87-MR-8	5	12	Golden Rule Insurance Company	Ken M. Walker a/k/a Ken [illegible]	
87-MR-9	5	13	Golden Rule Insurance Company	Darrell D. Crowley a/k/a Darrell D. Crowley + [illegible]	
-MR-10	5	20	Continental Casualty Company	Guy E. McGaughey Jr. etal	
-MR-11	5	21	Golden Rule Insurance Company	Andrew B. Artz	
-MR-12	7	7	The City of Lawrenceville, Illinois	Christine Joy Hancock	
-MR-13	8	3	In the Matter of the Change of Name of	James Daniel Harper, a Minor	
87-MR-14	8	28	In the Matter of the Extradition of David Franklin Young		
-MR-15	9	22	In the Matter of the Change of Name of	Jeremy Coy Williams, a Minor	
-MR-16	9	30	Golden Rule Insurance Company	Andrew Wallace	
-MR-17	10	23	Golden Rule Insurance Company	Matthew Benvenuto	
-MR-18	11	25	Golden Rule Insurance Company	Maria Monasheva	
-MR-19	11	25	Golden Rule Insurance Company	Richard L. Carter	
-MR-20	11	25	Golden Rule Insurance Company	Celine M. Seibert	
87-MR-21	12	11	William J. McCullough	Illinois State Board of Education, etal	
-MR-22	12	22	Golden Rule Insurance Company	John M. Teske	
-MR-23	12	23	Golden Rule Insurance Company	Edward A. Miller	
~~MR~~ 1988					
88-MR-1	1	4	Golden Rule Insurance Company	Jerome C. Dame	
-MR-2	1	25	Golden Rule Insurance Company	Mary Goin	
-MR-3	2	11	Golden Rule Insurance Company	Louis A. McLachlan	
-MR-4	2	11	Golden Rule Insurance Company	Rodney D. Peterson	
-MR-5	2	24	Golden Rule Insurance Company	Stephen G. Stromberg	
-MR-6	2	24	Golden Rule Insurance Company	Carrie Lee Ashby	
-MR-7	2	25	In the Matter of Henry R. Mason Jr.		
-MR-8	2	29	Golden Rule Insurance Company	Betty L. Waters	
-MR-9	3	31	Golden Rule Insurance Company	David Conoyer	
-MR-10	4	11	In the Matter of Subpoenas for Witnesses To Out of State Trial		
-MR-11	4	13	In the Matter of One 1979 Ford Pickup Truck		
-MR-12	5	16	The City of Lawrenceville, Illinois	Dale Grissom	

MISCELLANEOUS REMEDIES CASE NUMBER LIST

CASE NUMBER	DATE FILED MO.	DAY	FIRST NAMED PLAINTIFF	FIRST NAMED DEFENDANT	PERMANENT RECORD REEL NUMBER
88-MR-13	5	16	The City of Lawrenceville, Illinois	Gary Carroll Gray	
88-MR-14	5	18	In re: Selection of an Arbitrator in	the Matter of Don H. Baldwin etc.	
88-MR-15	5	25	Golden Rule Insurance Company	Billy J. Futrell	
88-MR-16	5	25	Golden Rule Insurance Company	Keith Stubenberg	
88-MR-17	6	7	Edna M. Beitey on behalf of Amanda Jean Bethe	Patricia Jean Montgomery	
88-MR-18	6	14	Golden Rule Insurance Company	Nancy S. Hobart	
88-MR-19	6	14	Golden Rule Insurance Company	Charles Stanley Maris	
88-MR-20	6	21	Golden Rule Insurance Company	Vera A. McNutt	
88-MR-21	6	27	In the Matter of Change of Name of Shondra Renee Shoulders, a Minor		
88-MR-22	7	29	Joseph Broussard	Industrial Commission of Illinois and Marathon Oil	
88-MR-23	8	24	Golden Rule Insurance Company	John P. Jones Jr. et al	
88-MR-24	8	30	Golden Rule Insurance Company	Dorothy R. Stark	
88-MR-25	9	6	Joseph Broussard	Industrial Commission of Illinois & Marathon Oil	
88-MR-26	9	12	Golden Rule Insurance Company	Alvin R. Chenault	
88-MR-27	9	13	Golden Rule Insurance Company	Virgil N. Rothrock, Sr.	
88-MR-28	10	19	Golden Rule Insurance Company	Mark Knotts	
88-MR-29	10	19	Golden Rule Insurance Company	Sherry E. Thurman	
88-MR-30	10	26	The City of Lawrenceville, Illinois	L. B. Strange, Trustee	
88-MR-31	10	26	The City of Lawrenceville, Illinois	Gerald D. Turner	
88-MR-32	10	27	The City of Lawrenceville, Illinois	Dale Brink and Patsy Brink	
88-MR-33	10	28	Golden Rule Insurance Company	Robert B. Edwards	
88-MR-34	12	1	Golden Rule Insurance Company	Paul E. Cole	
88-MR-35	12	27	The City of Lawrenceville, Illinois	Mildred Vaughn et al	
88-MR-36	12	27	The City of Lawrenceville, Illinois	Vern F. Miles and Lynda C. Miles	
88-MR-37	12	30	Golden Rule Insurance Co	Robert Axelrod	
88-MR-38	12	30	Golden Rule Insurance Co	Franklin Turner	
1989					
89-MR-1	1	6	Burl Johnson	Little Apparatus Corp. and Industrial Comm.	
89-MR-2	1	20	Kenneth Talley	Industrial Comm. and Snap-On Tool Co.	
89-MR-3	2	10	Golden Rule Insurance Company	George Andrews	
89-MR-4	2	28	Golden Rule Insurance Company	Mark V. Grabner	
89-MR-5	3	2	The City of Lawrenceville, Illinois	Royce Reeder and Dixie Reeder	
89-MR-6	3	3	Golden Rule Insurance Company	Merritt V. Kelly	
89-MR-7	3	9	Golden Rule Insurance Company	David M. Poole	
89-MR-8	3	16	The City of Lawrenceville, Illinois	Gertrude B. Jones, formerly Gertrude B.	
89-MR-9	5	1	Harry E. Stevenson	Raymond Buchanan	
89-MR-10	5	3	Golden Rule Insurance Company	Gary L. Downs	
89-MR-11	5	12	Golden Rule Insurance Company	Daniel S. Duran	
89-MR-12	5	17	Petition for Name Change – Morgan Rawlings Ogdahl		
89-MR-13	5	17	Petition for Name Change – Olivia Byrne Ogdahl		
89-MR-14	5	17	Petition for Change of Name – Matthew William Harr		
89-MR-15	5	22	Harry Ea Jones	Industrial Commission of Illinois and	[illegible] and
89-MR-16	6	1	Golden Rule Insurance Company	Lawrence J. Palmer	
89-MR-17	6	2	The People of the State of Illinois in the Interest of David Franklin Young	Harry Rice	

MISCELLANEOUS REMEDIES CASE NUMBER LIST

CASE NUMBER	DATE FILED MO.	DAY	FIRST NAMED PLAINTIFF	FIRST NAMED DEFENDANT	PERMANENT RECORD REEL NUMBER
89-MR-18	7	14	The City of Lawrenceville, Illinois	Dale Grievance, etal	
89-MR-19	7	21	Golden Rule Insurance Company	Martin A. Goldstone	
89-MR-20	7	21	Golden Rule Insurance Company	Jeffrey L. Haldeman	
89-MR-21	8	3	[illegible] Waterman	Blue Cross and Blue Shield Association	
89-MR-22	8	16	The Village of Birds, IL	John Devin	
89-MR-23	8	16	The Village of Birds, IL	Elizabeth E. Gyffin, a Minor	
89-MR-24	8	17	Golden Rule Insurance Company	Jamie L. Sadler	
89-MR-25	8	17	Golden Rule Insurance Company	Michael M. Raulston	
89-MR-26	8	26	Golden Rule Insurance Company	Richard A. Barker	
89-MR-27	10	6	Golden Rule Insurance Company	David [illegible] and [illegible]	
89-MR-28	10	18	Golden Rule Insurance Company	George Mueller	
89-MR-29	10	19	Golden Rule Insurance Company	Robert J. [illegible] and [illegible]	
89-MR-30	10	24	State's Attorney's Authorization for a	Petition and Order	
89-MR-31	10	26	Golden Rule Insurance Company	Betty Lou Campbell etc.	
89-MR-32	10	1	Jacob Constructors Inc.	Industrial Commission of Illinois & Donald R. Beard	
89-MR-33	11	1	Golden Rule Insurance Co.	Wayne R. [illegible]	
89-MR-34	11	1	Golden Rule Insurance Co.	Joseph [illegible]	
89-MR-35	11	9	W. Mark McFarland	Industrial Commission of Illinois and [illegible]	
89-MR-36	11	13	Golden Rule Insurance Company	Krista B. Davis	
89-MR-37	11	15	People of the State of Illinois	Robert Carrie	
89-MR-38	11	16	Golden Rule Insurance Company	Robert A. Meier and Anna F. Meier	
89-MR-39	11	22	Golden Rule Insurance Company	Rosa L. Lewis	
89-MR-40	12	5	People of the State of Illinois	Earl Johnson	
89-MR-41	12	11	Golden Rule Insurance Company	Matthew J. [illegible]	
89-MR-42	12	21	Golden Rule Insurance Company	Dallas E. King	
89-MR-43	12	28	Richard Clow	Industrial Commission of Illinois and City of Olney	
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					
-MR-					

MISCELLANEOUS REMEDIES CASE NUMBER LIST

CASE NUMBER 1990	DATE FILED MO	DAY	FIRST NAMED PLAINTIFF	FIRST NAMED DEFENDANT	PERMANENT RECORD REEL NUMBER
90-MR-1	1	9	Golden Rule Insurance Company	Ronald J. Olson	
90-MR-2	1	10	St. Paul Property and Liability Insurance Company	Taylor Miller, a minor by his next friends, Karen + Lou Mille	
90-MR-3	1	10	Golden Rule Insurance Company	Michael L. Sullivan	
90-MR-4	1	11	Golden Rule Insurance Company	James Ratliff and Catherine Ratliff	
90-MR-5	1	16	Golden Rule Insurance Company	Jim H. Patterson + D. Ann Patterson	
90-MR-6	2	2	Golden Rule Insurance Company	Clay Easley	
90-MR-7	2	2	Golden Rule Insurance Company	Alan S. Rudolph	
90-MR-8	2	2	Golden Rule Insurance Company	Annetta Oakley	
90-MR-9	2	5	Richard Cobos	Industrial Commission of Illinois and City of Chicago	
90-MR-10	2	6	Golden Rule Insurance Company	Scott E. Taylor	
90-MR-11	2	15	Golden Rule Insurance Company	Donald L. Kuczkowski	
90-MR-12	2	26	Robert Lester	Industrial Commission of Illinois and [illegible] Company	
90-MR-13	3	1	Golden Rule Insurance Company	Robert J. Baughman etc.	
90-MR-14	3	22	Golden Rule Insurance Company	Max E. Hale	
90-MR-15	3	28	Golden Rule Insurance Company	Harold C. Burkhalter	
90-MR-16	4	9	Golden Rule Insurance Company	Peter D. Lewis	
90-MR-17	4	9	Golden Rule Insurance Company	Mary P. Shupe	
90-MR-18	4	16	Golden Rule Insurance Company	Denise Frangipane	
90-MR-19	4	23	Golden Rule Insurance Company	William A. Dalziel	
90-MR-20	5	18	In Re the Interest of Phyllis Joan Rogers - Change of Name		
90-MR-21	5	30	The First National Bank in Sumner	John Peter Schmidt a/k/a Ronald J. Westhem, Richard Vi	
90-MR-22	5	31	In the Matter of Change of Name of Heschel Lee Brown and Victoria Marie LeHaup, Minors		
90-MR-23	6	21	Golden Rule Insurance Company	Robert T McAllister	
90-MR-24	7	2	Golden Rule Insurance Company	Darell E. Callen	
90-MR-25	7	13	Golden Rule Insurance Company	William C. Pickleton	
90-MR-26	7	16	Golden Rule Insurance Company	Zack Hamp	
90-MR-27	7	23	Golden Rule Insurance Company	Glenn C. Arand and Amy L. Arand	
90-MR-28	8	6	Midwest Transit, Inc.	Robert Berner d/b/a Berner + Associates	
90-MR-29	8	10	Golden Rule Insurance Company	Rheta M. Pace	
90-MR-30	8	15	Golden Rule Insurance Company	Cynthia S. Diederichsen	
90-MR-31	8	23	Golden Rule Insurance Company	Edward Osman and Diane Osman	
90-MR-32	9	10	Golden Rule Insurance Company	Todd E. Robbins	
90-MR-33	9	10	Golden Rule Insurance Company	Frank A. Elton + Deborah L. Elton	
90-MR-34	9	10	Golden Rule Insurance Company	Vernel Nate	
90-MR-35	9	12	Golden Rule Insurance Company	Young S. Ju	
90-MR-36	9	13	Golden Rule Insurance Company	Robert A. Wiard	
90-MR-37	9	24	Kathleen Redfern	Industrial Commission of Illinois and Central Industries	
90-MR-38	10	1	Golden Rule Insurance Company	Gus Roisentis etc.	
90-MR-39	10	1	Golden Rule Insurance Company	Norman D. Thuwenger	
90-MR-40	10	3	Golden Rule Insurance Company	Michael P. Frest	
90-MR-41	10	22	Golden Rule Insurance Company	Franklin T. Friedman M.D. + Physicians Ba	
90-MR-42	10	25	Golden Rule Insurance Company	Ben Warner Austin	
90-MR-43	10	25	Golden Rule Insurance Company	Harry A. Shelley	
90-MR-44	10	30	Golden Rule Insurance Company	Thomas C. Bielinski	

MISCELLANEOUS REMEDIES CASE NUMBER LIST

CASE NUMBER	DATE FILED MO.	DAY	FIRST NAMED PLAINTIFF	FIRST NAMED DEFENDANT	PERMANENT RECORD REEL NUMBER
90-MR-45	11	5	Golden Rule Insurance Company	Joel M. [illegible]	
90-MR-46	11	8	Golden Rule Insurance Company	David A. [illegible] etal	
90-MR-47	11	8	Golden Rule Insurance Company	Stuart Austin	
90-MR-48	11	8	Golden Rule Insurance Company	Rose M. Albright	
90-MR-49	11	8	Dennis Schmittler	Industrial Commission and [illegible]	
90-MR-50	11	16	Golden Rule Insurance Company	Linda F. Smith	
90-MR-51	11	21	In the Matter of the Petition to Form the Lawrence Public Library District.		
90-MR-52	12	5	Golden Rule Insurance Company	Roy L. Freeman, Jr.	
90-MR-53	12	7	Mideast Transit, Inc	Pawnee, Inc., etal.	
90-MR-54	12	21	Golden Rule Insurance Company	Glenn E. Cannon, Jr.	
90-MR-55	12	26	State's Attorney's Authorization and Application for Order		
90-MR-56	12	26	State's Attorney's Authorization and Application for Order		
1991 MR					
91-MR-1	1	3	Golden Rule Insurance Company	Ronald Richards	
91-MR-2	1	10	Golden Rule Insurance Company	Sharon Kay Hase	
91-MR-3	1	16	Golden Rule Insurance Company	Paul J. Long	
91-MR-4	1	28	Golden Rule Insurance Company	Helen L. Collins	
91-MR-5	1	28	Golden Rule Insurance Company	Lois J. Mampe	
91-MR-6	1	31	Golden Rule Insurance Company	John T. Lynch	
91-MR-7	2	7	Golden Rule Insurance Company	Robert A. [illegible], Jr.	
91-MR-8	2	7	Golden Rule Insurance Company	Theodore [illegible]	
91-MR-9	2	7	Golden Rule Insurance Company	Harry [illegible]	
91-MR-10	2	21	Golden Rule Insurance Company	Claud A. Koch	
91-MR-11	3	7	Golden Rule Insurance Company	Eddie E. Mann	
91-MR-12	3	7	Golden Rule Insurance Company	Nellie M. [illegible]	
91-MR-13	3	11	Golden Rule Insurance Company	Irene [illegible]	
91-MR-14	3	19	Golden Rule Insurance Company	Sharon L. Tate	
91-MR-15	3	22	Golden Rule Insurance Company	Peter C. McCheney etal	
91-MR-16	3	25	Golden Rule Insurance Company	Louise Toll	
91-MR-17	3	28	Golden Rule Insurance Company	Claudie [illegible]	
91-MR-18	4	5	Will Gibson, County Clerk		
91-MR-19	4	8	Golden Rule Insurance Company	Beatrice [illegible]	
91-MR-20	4	24	Golden Rule Insurance Company	Joseph A. Portello	
91-MR-21	5	10	Golden Rule Insurance Company	Michael J. [illegible]	
91-MR-22	5	14	Golden Rule Insurance Company	John Botak	
91-MR-23	5	15	Golden Rule Insurance Company	Thomas Hull and Henry Homer [illegible]	
91-MR-24	5	28	Golden Rule Insurance Company	Ricky D. Justice	
91-MR-25	5	31	Golden Rule Insurance Company	C. Gordon Baer	
91-MR-26	6	3	Golden Rule Insurance Company	Martha T. Kelley	
91-MR-27	6	6	Golden Rule Insurance Company	Franceway C. Stratton	
91-MR-28	6	13	Golden Rule Insurance Company	Dawn L. Walters	
91-MR-29	7	2	Golden Rule Insurance Company	Kelly D. Stone	
91-MR-30	7	8	Golden Rule Insurance Company	[illegible] aka [illegible]	
91-MR-31	7	8	Golden Rule Insurance Company	Anthony [illegible]	

MISCELLANEOUS REMEDIES CASE NUMBER LIST

CASE NUMBER	DATE FILED (MO DAY)	FIRST NAMED PLAINTIFF	FIRST NAMED DEFENDANT
91-MR-32	7 25	Extradition - Juvenile	
91-MR-33	7 25	Extradition - Jeffery Scott Ramsey	
91-MR-34	7 30	Golden Rule Insurance Company	Joseph P. Bennett, Jr.
91-MR-35	8 19	Golden Rule Insurance Company	Daniel W. Morgan
91-MR-36	8 21	In the Matter of Janie Elizabeth Jewell - Change of Name	
91-MR-37	8 21	Golden Rule Insurance Company	Linda Wageman
91-MR-38	8 29	Golden Rule Insurance Company	Johnetta S. [illegible]
91-MR-39	9 9	The City of Lawrenceville Illinois	Inez Goff and Opal Goff
91-MR-40	9 11	In Re: Subpoena to Custodian of Records, Golden Rule Insurance Co.	
91-MR-41	9 12	The City of Lawrenceville, Illinois	A. Lee Heath et al
91-MR-42	9 12	The City of Lawrenceville, Illinois	Dale L. Griesemer, et al
91-MR-43	9 12	The City of Lawrenceville, Illinois	Dale L. Griesemer et al
91-MR-44	9 25	State's Attorney's Authorization and Application for [illegible]	
91-MR-45	9 25	State's Attorney's Authorization and Application for [illegible]	
91-MR-46	10 2	In the Matter of Ione Ceric - Change of Name	
91-MR-47	10 7	Joyce [illegible]	Industrial Commission of Illinois and [illegible] Co.
91-MR-48	10 21	Golden Rule Insurance Company	Scott J. Hensen
91-MR-49	10 21	Golden Rule Insurance Company	John Frantzis
91-MR-50	10 24	In Re: Application of Carolyn [illegible] - Name Change	
91-MR-51	10 31	Golden Rule Insurance Company	Edward L. [illegible]
91-MR-52	10 31	Daniel Joe Miller	[illegible] Company and Michigan [illegible]
91-MR-53	11 5	Jackie L. Davis	Industrial Commission of Illinois and [illegible]
91-MR-54	11 7	Extradition of Leigh Ann [illegible]	
91-MR-55	11 25	Extradition of Mike Barton	
91-MR-56	12 18	Golden Rule Insurance Company	Timothy J. Moran
91-MR-57	12 19	The City of Lawrenceville Illinois	Dale L. Griesemer, et al.
91-MR-58	12 19	The City of Lawrenceville, Illinois	John L. Bowman
91-MR-59	12 20	Golden Rule Insurance Company	Christopher S. Rohe
91-MR-60	12 23	Golden Rule Insurance Company	David O. Patterson
MR 1992			
92-MR-1	2 14	Golden Rule Insurance Company	Robert A. Bonsau
92-MR-2	2 5	Neal Thomas Ravellette	(Change of Name)
92-MR-3	2 10	Golden Rule Insurance Company	Erik Klinzing
92-MR-4	2 24	The City of Lawrenceville, Illinois	John Wesley Goodart, Jr., et al
92-MR-5	2 24	The City of Lawrenceville, Illinois	Arthur Hasbury, et al
92-MR-6	2 24	Golden Rule Insurance Company	Thelma L. McCoy
92-MR-7	4 6	Diamond III, Inc.	Continental Insurance Company
92-MR-8	4 9	Melinda A. Dunlap	Petition for Change of Name
92-MR-9	4 9	Golden Rule Insurance Company	Robert J. [illegible]
92-MR-10	4 9	Golden Rule Insurance Company	William G. Liebold
92-MR-11	4 16	Victoria Jean Cozadd	Petition for Change of Name
92-MR-12	4 16	Julie Belle Cozadd	Petition for Change of Name
92-MR-13	4 16	Jo-Belle Victoria Cozadd	Petition for Change of Name

MISCELLANEOUS REMEDIES CASE NUMBER LIST

CASE NUMBER	DATE FILED MO	DATE FILED DAY	FIRST NAMED PLAINTIFF	FIRST NAMED DEFENDANT	PERMANENT RECORD REEL NUMBER
92-MR-14	4	23	Golden Rule Insurance Company	Robert S. [illegible], Jr.	
92-MR-15	5	8	Golden Rule Insurance Company	William [illegible]	
92-MR-16	5	19	The City of Lawrenceville, Illinois	Jack Horton	
92-MR-17	5	26	In the Matter of Yvonne M. Steele, a witness		
92-MR-18	6	24	The City of Lawrenceville	Bobbie Wilson, etal	
92-MR-19	8	13	In the Matter of the Appointment of Special Attorney		
92-MR-20	8	17	Golden Rule Insurance Company	Jeniane K. Sterken	
92-MR-21	8	18	The City of Lawrenceville, Illinois	Timothy Stone	
92-MR-22	9	10	Henry C. Kendall	John N. Baker etal	
92-MR-23	9	15	Extradition of Eugene Hood		
92-MR-24	9	18	Aqrol Ann Gibson	Robert James Hervin	
92-MR-25	9	30	Petition for Change of Name - Andrew Johnson Hampton, Jr.		
92-MR-26	10	13	Petition for Change of Name - Lexie Ella Hunsinger		
92-MR-27	10	16	Continental Western Insurance Co.	City of Sumner, John A. Clem + Michael Lloyd [illegible]	
92-MR-28	11	2	Petition for Change of Name - Charles Andrew Allen		
92-MR-29	11	25	William Reginald Padgett	Reginald Lee Padgett etal	
92-MR-30	12	18	Nu-Life, Inc. of Illinois	The Department of Employment Security, State of Illinois, etal	
92-MR-31	12	23	Petition for Change of Name - Jennifer Jo Cogswell		
1993					
93-MR-1	1	14	Golden Rule Insurance Company	Donald L. Coy	
93-MR-2	2	8	In the Matter of Yvonne M. Steele, a Witness		
93-MR-3	4	20	Golden Rule Insurance Company	Paul A. Maloy	
93-MR-4	5	10	People of the State of Illinois	Michael Bradley Chappell	
93-MR-5	5	11	State's Attorneys Application for Order		
93-MR-6	5	13	Golden Rule Insurance Company	William N. Lobuda	
93-MR-7	5	21	Petition for Change of Name - Amy Rose Rowland		
93-MR-8	5	28	Golden Rule Insurance Company	Elias Andreakes	
93-MR-9	6	11	Golden Rule Insurance Company	Nancy Myers	
93-MR-10	6	23	People of the State of Illinois	William Allen Stevens a/k/a William A. [illegible]	
93-MR-11	7	6	Petition for Change of Name - Tonya Leanne Selinske		
93-MR-12	7	20	In Re Appointment of Election Judges		
93-MR-13	8	26	Linda S. Miller	Ill. Industrial Comm. and Briggs Plumbingware, Inc.	
93-MR-14	8	30	People of the State of Illinois	Robert William Davis	
93-MR-15	9	3	Golden Rule Insurance Company	Board of Review of the Dept. of Employment Security	
93-MR-16	9	17	Golden Rule Insurance Company	Scott Heuser	
93-MR-17	9	22	People of the State of Illinois	Tracy C. Wilson	
93-MR-18	10	4	States Attorney's Application for Order		
93-MR-19	11	18	Petition for Change of Name - [illegible]		
93-MR-20	10	21	People of the State of Illinois	David E. Quinn	
93-MR-21	12	13	People of the State of Illinois	Homer Cooper	
93-MR-22	12	14	People of the State of Illinois	David W. Young	
-MR-					
-MR-					
-MR-					

Mr. DINGELL. Thank you, Mr. Hough.

Mr. Hough, Ms. Groenke, we have a problem that the bells are ringing again.

I want to be considerate of you and your time.

Let me ask if this is acceptable. If we were to ask the oral questions of Ms. Groenke and if we were to send you the written questions that we wanted for inclusion in the record, would that be acceptable?

Mr. HOUGH. That would be fine with me.

Mr. DINGELL. I apologize, but the House Floor doesn't always cooperate with us over here.

I want to commend you, Mr. Hough, for what you have done and also for your very fine statement to the committee, and thank you for your presence here.

Ms. Groenke, thank you also for your assistance.

I am sorry. The Chair is going to recognize my good friend from Colorado.

Mr. SCHAEFER. Just very briefly, Mr. Hough, the attorney in Colorado, was it Hannon?

Mr. HOUGH. Kevin Hannon, yes, sir, he is in Denver.

Mr. SCHAEFER. We would like to have that correspondence also as a part of the record.

Mr. HOUGH. I have given it to the subcommittee and I will be more than happy, I brought it with me today. In fact, I even put his new phone number on it.

Mr. SCHAEFER. That is all I had, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman.

The Chair apologizes.

Ms. Groenke, the bottom line in your case is that initially Golden Rule refused to pay any of your medical bills arising from your hospital stay, is that correct?

Ms. GROENKE. Yes.

Mr. DINGELL. Now, what types of things were billed, were you billed for? I believe doctors' bills, laboratory services as well as your hospital stay, is that correct?

Ms. GROENKE. That is right.

Mr. DINGELL. I believe the initial pricetag was somewhere between $5,000 and $7,000, is that correct?

Ms. GROENKE. Yes.

Mr. DINGELL. Now, Golden Rule refused to pay all your bills. Did you then go ahead and pay the bills for hospital and doctors yourself?

Ms. GROENKE. No. I was unemployed at the time and wasn't able to.

Mr. DINGELL. You could not do that. So what reasons did Golden Rule give you for refusing to pay your bills?

Ms. GROENKE. They had sent me an addendum to my original application which detailed what they called "preexisting conditions."

Mr. DINGELL. Your hospitalization, however, was in no way associated with any "preexisting conditions;" was it?

Ms. GROENKE. No, my hospitalization was determined to be the cause of a virus which resulted in a severely high fever and dehydration.

Mr. DINGELL. So after you had grappled with Golden Rule and the bill collectors at the hospital, you finally went to the Maryland Insurance Department in desperation, is that correct?

Ms. GROENKE. Yes.

Mr. DINGELL. And, in fact, in Maryland, the insurance commissioner ruled in your favor; is that right?

Ms. GROENKE. Yes, he helped me greatly.

Mr. DINGELL. In order for Golden Rule then to cover your hospital stay, you had to pay the company considerably more than your original $84 premium for 1/4 of a year, is that correct?

Ms. GROENKE. Yes, it is.

Mr. DINGELL. Golden Rule wanted you to pay them an extra $513.04 for an additional 3 months of coverage, is that right?

Ms. GROENKE. Yes.

Mr. DINGELL. Once again, the Maryland Department of Insurance intervened and it cost you only $167.58 for the original 3 months coverage, is that right?

Ms. GROENKE. Yes.

Mr. DINGELL. Now, the $167.58 was just enough to force Golden Rule to pay your hospital bills, is that correct?

Ms. GROENKE. Yes.

Mr. DINGELL. But it didn't provide you with any additional coverage, did it?

Ms. GROENKE. No, it didn't.

Mr. DINGELL. So after your ordeal with Golden Rule, I assume you shopped around for another insurer. If so, were you successful?

Ms. GROENKE. Yes, and about that same time I became employed.

Mr. DINGELL. Who did you get and what are your premiums?

Ms. GROENKE. My employer pays my premiums now.

Mr. DINGELL. And you obtained coverage from a new employer?

Ms. GROENKE. Yes.

Mr. DINGELL. Ms. Groenke, you are obviously an articulate and discerning individual, and I can only assume you did your best to respond truthfully in your original application. Would your experience with Golden Rule suggest to you that these applications were written specifically to afford the company the broadest possible latitude in interpreting what does and what does not constitute preexisting conditions, not to mention other potential loopholes which they could then assert against the insured?

Ms. GROENKE. Yes.

Mr. DINGELL. Now, as a consumer, don't you think that a clearer definition of benefits, standards, premium comparison data and company claims history would be helpful in enabling the purchaser of insurance to make a better informed choice about the insurance company which he or she would pick?

Ms. GROENKE. Yes.

Mr. DINGELL. Do you have copies of the papers that you submitted to Golden Rule and the specific addendum that you failed to sign?

Ms. GROENKE. Yes.

Mr. DINGELL. Would you make that available to the committee, please?

Ms. GROENKE. Yes, I will.

Mr. DINGELL. We would very much appreciate it.

Ms. Groenke, we thank you for your assistance to the committee.

Ms. GROENKE. Thank you.

[The prepared statement with attachments of Ms. Groenke follows:]

PREPARED STATEMENT OF KATHRYN KRISTINE GROENKE

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to appear before you to share my experience. My remarks will be brief.

In early March 1992, I applied for major medical insurance coverage from Golden Rule Insurance Company through Mr. Robert Kerth, life and benefits specialist, Bishop, Showalter and Moody. With my application, I enclosed a check for $83.79 for three months coverage. At the time of the application, Mr. Kerth informed me that I would be covered by Golden Rule upon receipt of my application and check.

On March 19, 1992, Golden Rule Insurance Company cashed the check.

In early April 1992, a representative of Golden Rule contacted me with questions about my previous medical history. After a short discussion, I questioned her about my coverage and if the issues we were discussing would inhibit my ability to be covered by Golden Rule. She assured me that if the previous medical problems were not on-going then they did not constitute a preexisting problem. I assured her that nothing we were discussing was ongoing, nor did I expect them to pose a problem in the future. Once again, she said these issues should not cause a coverage problem.

Within a few days, I received an amendment to my application which detailed our telephone conversation. The instructions were to sign and return the amendment before April 7, 1992 or the company would quit processing my application.

After receiving the amendment, I heard nothing more from Golden Rule Insurance Company until I entered the hospital and made a claim against my insurance policy on April 20, 1992.

On Saturday, April 18, 1992, I was admitted to the emergency room at St. Joseph's Hospital in Baltimore, Maryland with an unusually high and persistent fever and severe dehydration. Because of the Easter weekend, I was unable to inform my insurance company that I was admitted to the hospital until Monday, April 20, 1992. At that time, I contacted Mr. Kerth, insurance specialist. He contacted Golden Rule on my behalf.

At that time, Mr. Kerth was informed that Golden Rule had not received the signed amendment.

By agreement with Golden Rule's regional office in Pennsylvania, from the hospital facsimile machine in Patient Services, I faxed a copy of the signed amendment. I received a fax report indicating that the copy had been sent and received. It took the insurance company's Pennsylvania office more than 24 hours to locate the faxed copy.

On Tuesday, April 21, 1992, the insurance company office in Lawenceville, Illinois informed Mr. Kerth that they could not work from the faxed copy while the regional office denied agreeing to even accept a faxed copy. At that time, Golden Rule informed Mr. Kerth that they intended to deny my application for coverage.

While I acknowledge my failure to return the amendment, I believe that the company accepted coverage when they cashed my check and used my money, interest free, for a month before notifying me that they intended to deny my application.

Clearly, the decision *not* to accept my application for coverage was based on my claim against the company rather than my failure to return the amendment; or I would have been informed of the coverage denial earlier *and* I would have received a refund before the end of April.

Denial of coverage was not based on any on-going or preexisting medical conditions. If the denial was based on any valid reason, my hospitalization on April 18 would have been related to the prior medical conditions and procedures discussed in the amendment.

Since the hospitalization was due to an unexplained high fever and resulting dehydration now attributed to a "virus," I believe Golden Rule Insurance Company attempted to fraudulently deny me coverage to avoid paying expensive hospital and doctor charges.

I am convinced that Golden Rule was continuing to process my application after April 7, 1992 up to and until I made a claim against them on April 20, 1992. The letter from Golden Rule denying my application for coverage was dated April 22, 1992.

Furthermore, I am convinced that if I had not made a claim against the policy, I would have not experienced a problem with the health insurance company.

For almost two months, I worked directly with Golden Rule to try to resolve these issues, but to no avail.

Therefore, on June 12, 1992, I filed a formal complaint against Golden Rule Insurance Company with the Maryland Department of Licensing and Regulation, Insurance Division.

On June 24, 1992, Paul Spector, a state insurance investigator, contacted Golden Rule on my behalf and requested a response to the charges I had lodged against the company.

On July 9, 1992, I received a formal response from Golden Rule signed by Charlotte Binkley, underwriting supervisor. According to Golden Rule, my application had been denied on April 21, 1992 due to a lack of a signed amendment. This date and the date of my hospitalization were merely coincidental, according to the response, and had the Underwriting Department known of my hospitalization my application file would have remained open.

Again, Golden Rule was officially informed of my hospitalization on April 20, 1992.

At the time of the response, Golden Rule Insurance Company offered to reconsider my application for insurance from the original proposed effective date of March 12, 1992. The offer specified that if my hospitalization was not related to the items detailed in the application amendment, the hospitalization would be covered by the policy. In order to validate this offer, according to the company, I had to return a signed amendment and a check for $513.04.

On July 27, 1992, I returned the signed amendment along with payment for coverage from March 12, 1992 through June 12, 1992. The time period for which I had originally requested coverage.

On August 14, 1992, I received a letter from Golden Rule Insurance Company accepting my application for insurance from March 12, 1992 through June 12, 1992. At this time, the company agreed to begin processing my hospitalization bills for payment.

Eventually, all doctor and hospital bills incurred during my hospitalization which began April 18, 1992 were covered.

ATTACHMENTS

Golden Rule

WILLIAM SIDWELL
6817 WINTON RD
FINNEYTOWN OH
45224-1328

April 22, 1992

RE: Kathryn K Sidwell
053525914

Dear William Sidwell:

Thank you for the application for insurance on Kathryn K Sidwell.

The Company naturally tries to extend coverage to all those who are interested in our plan of insurance. However, we have determined that we are unable to provide coverage for the above referenced applicant under this plan.

You will receive a refund check for $83.79 under separate cover.

Your refund check includes the initial dues submitted for membership in the Federation of American Consumers and Travelers (F.A.C.T.). As we are not collecting premiums, we cannot act as a collection vehicle for your F.A.C.T. dues. If you plan to continue your F.A.C.T. membership, you should contact F.A.C.T. to arrange for dues payment. You may contact F.A.C.T. by calling 1-800-872-3228.

We wish to thank you for your interest in Golden Rule.

Sincerely,

Suzanne Devan
Suzanne Devan
New Business Department

cc: ROBERT L KERTH

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

RECEIVED
JUN 17 1992
INSURANCE DIV.

June 12, 1992

Maryland Insurance Department
501 St. Paul Place
Baltimore, MD 21202

Attn: Complaints and Investigations

I am writing to lodge a formal complaint against the Golden Rule Insurance Company of Lawrenceville, Illinois.

In early March, 1992, I applied for major medical insurance coverage from Golden Rule through Life and Benefits Specialist, Mr. Robert Kerth with Bishop, Showalter, and Moody, 18233-A Flower Hill Way, Gaithersburg, Maryland 20879, (301) 417-0001. With my application, I enclosed check no. 1945 dated March 5, 1992 in the amount of $83.79 for three months coverage. The check was cashed by Golden Rule March 19, 1992. At the time of the application, Mr. Kerth informed me that I would be covered by Golden Rule upon receipt of my application and check.

Several weeks later in April, a representative of Golden Rule contacted me with questions about my previous medical history. After a short discussion, I questioned her about my coverage and if the issues we were discussing would inhibit my ability to be covered by Golden Rule. She assured me that if the previous medical problems were not on-going they did not constitute a pre-existing problem. I assured her that none of the things we were discussing were on-going problems, nor did I expect them to pose a problem in the future. Once again, she assured me that they should not cause a coverage problem.

Within a few days, I received an amendment to my application which detailed our telephone conversation (copy enclosed). The instructions were to sign and return the amendment before April 7, 1992, or the company would quit processing my application. After receiving the amendment, I heard nothing more from Golden Rule Insurance Company until I entered the hospital and made a claim against my insurance policy.

On Saturday, April 18, 1992, I was admitted to the emergency room at St. Joseph's Hospital in Baltimore, Maryland, with an unusually high and persistant fever and dehydration. Because of the Easter weekend, I was unable to inform my insurance company that I was admitted to the hospital on Sunday, April 19, 1992 until Monday, April, 20, 1992. At that time, I contacted my insurance specialist, Mr. Robert Kerth. Mr. Kerth contacted Golden Rule for me.

Upon contacting the company, Mr. Kerth was informed that they had not received the signed amendment. By agreement with Golden Rule's regional office in Pennsylvania, from the hospital facsimile machine in Patient Services, I faxed a copy of the signed amendment. I received a fax report indicating that the copy had been sent and received. It took the insurance company office more than 24 hours to locate the faxed copy.

On Tuesday, April 21, 1992, the insurance company office in Lawrenceville, Illinois informed Mr. Kerth that they could not work from the faxed copy while the regional office denied agreeing to even accept a faxed copy. At that time, Golden Rule informed Mr. Kerth that they intended to deny my application for coverage. While I acknowledge my failure to return the amendment, I believe that the company accepted coverage when they cashed my check and used my money, interest free, for a month before notifying me that they had denied my application.

Clearly, the decision not to accept my application for coverage was based on the fact that I made a claim against the company rather than my failure to return the amendment or I would have been informed of the coverage denial earlier and received a refund before the end of April. The denial of coverage had nothing to do with any medical conditions, on-going or pre-existing. If they were based on valid reasons, my hospitalization would be related to the prior medical conditions and procedures discussed in the enclosed amendment. Since the hospitalization was due to an unexplained high fever and resulting dehydration now attributed to a "virus", I feel very strongly that I was denied coverage fraudulently by Golden Rule Insurance Company.

I believe that my money was accepted under fraudulent circumstances by Golden Rule Insurance Company. I believe that Golden Rule was continuing to process my application after April 7, 1992 until I made a claim against them on April 20, 1992. The letter from Golden Rule denying my application is dated April 22, 1992 (copy enclosed). If I had not made a claim against the company, I believe I would still be covered by health insurance.

I respectfully request that the Office of Insurance Commissioner review the validity of my claim against Golden Rule Insurance and the legality of their denial of coverage to me. Please provide me with information about my rights under the laws of Maryland pertaining to health insurance coverage.

Thank you for your efforts on my behalf. I look forward to your response.

Sincerely,

6F Roman Knoll Ct.
Cockeysville, MD 21030

K. Kristine Sidwell
(H)# (410) 628-4805
(W)# (202) 872-8110

STATE OF MARYLAND
WILLIAM DONALD SCHAEFER
Governor

WILLIAM A. FOGLE, JR
Secretary

JOHN A DONAHO
Insurance Commissioner

Department of Licensing and Regulation
INSURANCE DIVISION

501 ST. PAUL PLACE
BALTIMORE, MARYLAND 21202-2272

DIRECT DIAL (410) 333-

A Regulator Helping People

June 24, 1992

Golden Rule Insurance Company
Golden Rule Building
712 11th Street
Lawrenceville, Illinois 62439
Attn. Lisa Low, Secretary

RE: **Our File No. 408-27-06-92**
Inquirer: K. Kristine Sidwell

Dear M's. Low:

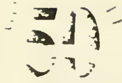
Enclosed is a copy of a letter sent to us from the complainant referred to above. Please reply to us covering the points raised in that letter and advise us of the basis for your position, with copies of supporting documents where indicated.

By copy of this letter to the complainant we wish to acknowledge the complainant's letter. A further reply will be made as soon as our investigation permits.

Sincerely,

Paul H. Spector, CLU
Insurance Investigator

PHS/cat
Enclosure
cc: **K. Kristine Sidwell**
6 F Roman Knoll Court
Cockeysville, Maryland 21030



Golden Rule®

K. Kristine Sidwell
6 F Roman Knoll Court
Cockeysville, MD 21030

RE: #053525914 July 9, 1992

Dear Ms. Sidwell:

We have received an inquiry from Paul H. Spector, Insurance Investigator, with the state of Maryland. Your file has been referred to me for review and a response.

Your application was declined on April 21, 1992, due to a lack of signed amendment. The Conditional Receipt given to you at the time of application states that coverage will not become effective until it is approved by Golden Rule (Exhibit A). _If_ coverage is approved, the effective date would be the date Golden Rule received the application. The application also states that the application and payment of initial premium does not give immediate coverage (Exhibit B).

Unfortunately, our Underwriting Department was not aware of your hospital admission on April 18, 1992, at the time your application was declined. We did indicate in our letter that the amendment was due April 7, 1992. However, we typically give applicants additional time if possible. The fact that our decline letter was so near the date of your hospitalization is merely coincidental. I _do_ apologize that our internal communications were not better. Had our Underwriting Department known of your hospitalization we would have kept your file open. We would have investigated to determine if the hospitalization resulted from a condition that began prior to the proposed effective date and therefore, would affect insurability.

We are willing to reconsider your coverage with the original proposed effective date of March 12, 1992, the date we received your application. Enclosed is a new amendment, in case you no longer have the original. We do not accept faxed copies of amendments; we require an original signature. Please mail this to us upon receipt of this letter.

lden Rule Insurance Company

lden Rule Building
0 Woodland Drive
ianapolis, Indiana 46278-1719
ephone (317) 297-4123

K. Kristine Sidwell
July 9, 1992
Page 2

Because of the recency of your hospitalization to the proposed effective date, we will investigate your past medical history and the conditions resulting in your hospitalization on April 18, 1992, to determine insurability. If the condition that caused your hospitalization is found to have existed prior to the application for coverage or prior to the proposed effective date, coverage may not be offered or the condition may be excluded from coverage.

Please be assured that we will conclude this matter as soon as possible. We have requested medical records from the University of Minnesota Boyton Health Services and St. Joseph's Hospital. These are due by July 30, 1992.

If coverage is offered, we will need initial premium of $513.04 before we could issue the certificate and reconsider any claims incurred.

Please do not hesitate to contact the University of Minnesota Boyton Health Services and St. Joseph's Hospital to speed up the processing of the necessary medical records. We will inform you upon receipt of your signed amendment and medical records.

Sincerely,

Charlotte Binkley
Underwriting Supervisor

CB/pw

Enclosures

cc: Paul H. Spector, Insurance Investigator
State of Maryland
Robert L. Kerth

July 27, 1992

Golden Rule Insurance Company
Golden Rule Building
7440 Woodland Drive
Indianapolis, IN 46278-1719

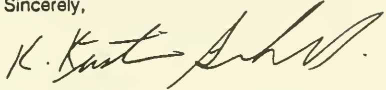
Dear Ms. Binkley,

I am returning the amendment to application for file #053525914 along with payment for coverage from March 12, 1992 through June 12, 1992.

Please find a check for $167.58 enclosed. Payment for $83.79 was enclosed with the original application, please find your check enclosed.

If I can be of any further assistance, please do not hesitate to contact me.

Sincerely,



K. Kristine Sidwell

cc: Paul Spector, MD Insurance Investigator

Golden Rule®

Golden Rule Insurance Company

Home Office
Golden Rule Building
Lawrenceville, Illinois 62439
Telephone (618) 943-8000

AMENDMENT
TO
APPLICATION FOR INSURANCE

RE: 053525914

The application of Kathryn K. Sidwell, dated March 3, 19 92 is hereby amended as follows:

Question #15j Abnormal pap smear; the last one six months ago was normal. There was no malignancy involved or further treatment advised. Question #15k is wears glasses. Question #17a is birth control pills. Question #19 is bunionectomy on each foot; no further treatment needed. University of Minnesota, Boyton Health Service treated you for knee pain, colds, flu, and checkups; with all results being normal. Surgery has been advised for your left knee.

I hereby represent that the above answers and statements are correct, complete and wholly true to the best of my knowledge and belief and that they are to be considered as a part of the original application for insurance. I further represent that the answers and statements contained in the original application, except to the extent they are amended by the above, are still correct, complete and wholly true to the best of my knowledge and belief.

Signed at *Residence* Date *7/13/92*

Witness *[signature]* Signature of Applicant *[signature]*

SA-AP 1

Years of Dedication

Golden Rule®

RECEIVED
AUG 17 1992
INSURANCE DIV.

Kathryn Kristine Sidwell
507 Albany Avenue
Silver Spring, MD 20912-4139

RE: File No. 053525914

August 14, 1992

Dear Ms. Sidwell:

I received your premium of $251.37. Your certificate was inforce from March 12, 1992, until June 12, 1992, as requested.

Enclosed is your certificate which was terminated effective June 12, 1992.

I will forward your file to our Claims Department for processing of submitted claims.

Sincerely,

Charlotte Binkley
Underwriting Supervisor

CB/pw

Enclosure

cc: Robert Kerth
Paul Spector
DOI File No. 408-27-06-92

Golden Rule Insurance Company

Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719
Telephone (317) 297-4123

Mr. DINGELL. Mr. Hough, I mispronounced your name for which I apologize to you.

Mr. HOUGH. It happens all the time.

Mr. DINGELL. We will communicate with you in writing, Mr. Hough, then your responses will be inserted in the record, and we do thank you for your assistance to us.

Mr. HOUGH. Thank you.

Mr. DINGELL. The Chair will also insert in the record the statement of my good friend, the Honorable Carlos Moorhead, with regard to the matters into which the subcommittee is inquiring today.

The subcommittee will now stand adjourned.

We will look forward to a continuation of these hearings at an early time.

[Whereupon, at 2:23 p.m., the subcommittee was adjourned.]

[The prepared statement of Hon. Carlos J. Moorhead follows:]

PREPARED STATEMENT OF HON. CARLOS J. MOORHEAD, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Thank you Mr. Chairman. Few issues have been in the national consciousness as much recently as health insurance. The Subcommittee today will begin to look in detail at various practices engaged in by health insurance companies, in what promises to be a most enlightening series of hearings.

Like the other health care entities the Subcommittee has examined, the health insurance industry is changing. Many of those changes are being forced upon it by reforms at the State level; many are occurring on companies' own initiative, as everyone tries to stay ahead of the curve, to be "lean and mean" while still being able to operate profitably.

I look forward to our examination of current trends in this regard, and their effect on insurance consumers. Thank you Mr. Chairman.

HEALTH INSURANCE INDUSTRY PRACTICES

WEDNESDAY, AUGUST 3, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. John D. Dingell (chairman) presiding.

Mr. DINGELL. The subcommittee will come to order.

Today the subcommittee is continuing its investigation into the health insurance industry. This is a mammoth industry and it has an all but unfettered ability to determine who does and who does not get health insurance; how and how much the fortunate or unfortunate pay for it and what they get for their money and who does not get this insurance. Their decisions can destroy the physical and the financial wellbeing of millions of Americans. Their decisions and corporate practices in all too many cases can and have contributed mightily to the economic tailspin caused by unchecked health care inflation. Despite their obvious power and crucial role in orchestrating changing trends in the medical marketplace, they enjoy a surprisingly lax regulatory environment.

The subcommittee, therefore, intends to take a long, hard look at how the health insurance industry works and how it affects us as individuals and as a society. And we intend to find out what is wrong with the way we currently regulate the industry and what we need to do to correct the flaws and to close the gaps.

Today, we will focus on the activities of Golden Rule Insurance Company. Testimony at our first hearing in this subcommittee on June 29 suggested that this company—the largest one still offering individuals policies—richly deserves closer scrutiny. Specifically, regulators, legislators, and consumers from six different States testified that Golden Rule: routinely engages in extraordinary practices designed to intimidate, coerce and frighten; sues regulators who refuse to grant them more and bigger rate increases than their competitors; sues their own policyholders in some cases rather than to pay off their claims; it bullies legislators in an effort to kill health care reforms and spends hundreds of thousands of dollars lobbying against these reforms; and scares consumers with doomsday predictions shored up by misinformation and threats of cancelled policies.

Are any of these actions illegal? Probably not. Are they good business for the company's bottom line? Definitely. Are they good

for consumers? Almost certainly no. Do they make for sound public policy? I don't believe so.

We are eager to hear Golden Rule's response to these allegations which I regard as serious. We do know that historically the company has couched its actions by railing against big government and wrapping itself in the flag, claiming that they are protecting their constitutional rights. We have no desire to impair the constitutional rights of anyone, in business or out, as we examine these matters in the future.

Today we will also hear from consumer advocates, from State regulators and legislators. We look forward to their testimony and to working with them in these matters in this session and in future as we discuss issues which I regard as very important and which do affect the welfare and wellbeing of Americans everywhere.

The Chair notes that our first panel is composed of Ms. Cathy Hurwit, Director of Legislative Affairs, Citizen Action. Ms. Hurwit, we are happy to welcome you to the committee. You are familiar with the proceedings of the committee.

Do you have objection to testifying under oath?

If not, you have a right to be advised by counsel if you so choose while testifying under oath. Copies of the Rules of the Subcommittee, the Committee and the House of Representatives are there to inform you of your rights and limitations on the power of the subcommittee.

[Witness sworn.]

Mr. DINGELL. You may consider yourself under oath and you are recognized for such statement you choose to make. I'm sorry, does the gentleman from Colorado desire to be recognized for an opening statement?

Mr. SCHAEFER. Mr. Chairman, I do have an opening statement but——

Mr. DINGELL. The Chair recognizes the gentleman at this time.

Mr. SCHAEFER. I would be very brief and ask it be submitted as part of the record.

As we continue our examination of the health insurance industry, I look forward to seeing and hearing the witnesses we have today, particularly, may I say, my good friend, Representative Mike Coffman, from Colorado, who carried a bill this year in the Colorado legislature. We are very much interested in hearing him.

Mr. DINGELL. Without objection the full statement of the gentleman will be inserted in the record.

[The prepared statement of Hon. Dan Schaefer follows:]

PREPARED STATEMENT OF HON. DAN SCHAEFER

Thank you, Mr. Chairman. The subcommittee returns today to its examination of the health insurance industry, and particularly to the practices of Golden Rule Insurance Company.

I am pleased to see the company represented today, by its chief executive officer John M. Whelan. A number of questions arose at our last hearing on the subject, and it will be helpful to have Mr. Whelan here to respond to them and to other issues that will be raised at today's hearing.

I want to welcome all of our witnesses here today, but I would especially like to welcome Representative Mike Coffman from the State of Colorado. Representative Coffman sponsored Colorado's recent health insurance reform legislation and was instrumental in getting it enacted into law. As we heard at our June hearing, Golden Rule was a vociferous opponent of this legislation, as well as similar efforts in

other States. We will be quite interested in hearing your firsthand view of Golden Rule's tactics in this regard.

I look forward to the testimony to be presented today, as we continue to explore the many troubling matters brought to our attention a little more than a month ago. Thank you, Mr. Chairman.

Mr. DINGELL. The gentleman is well aware of the fact that I am one of the few natives of Colorado that can make an honest claim on that point. Representative, we will be happy to have you here. I am sure you will assist us and I know that both of you have the welcome of my good friend Mr. Schaefer.

Ms. Hurwit, welcome to the committee. We recognize you for such statement as you choose to make.

TESTIMONY OF CATHY HURWIT, LEGISLATIVE DIRECTOR, CITIZEN ACTION

Ms. HURWIT. Thank you very much, Mr. Chairman. It is a pleasure to be here today, and I thank you and the subcommittee for your interest in protecting the rights of health care consumers.

The purpose of insurance is to spread risk and to protect consumers against the possibility of illness or injury. Health coverage is not a luxury in today's world; it is a necessity, but too many Americans lack that necessity.

As you know, Mr. Chairman, Citizen Action does not support a private insurance-based health care system in which companies like Golden Rule get to decide who is covered, what they pay and what treatments will be reimbursed. If, however, this Congress is going to continue to allow private insurance companies like Golden Rule to run the health care system, then we believe that significant changes in regulation are needed in order to avoid serious existing problems.

Citizen Action began to explore the practices of Golden Rule after receiving complaints from our State organizations about its behavior. Of course, Golden Rule is not alone in being the cause of consumer concern, but it is a prime example of the problems which can occur in this market and which are confronting consumers daily.

As you have said, Mr. Chairman, Golden Rule is perhaps the largest writer of individual health insurance in the country. It has come under criticism by consumer groups for a number of years. For example, in the June 1989 issue of Consumer Reports, the authors found that Golden Rule has the toughest standards, rejecting 20 to 30 percent of all applicants who are 65, and as many as 50 percent of those who are 70; that is for their Medigap coverage. Even looking at the reports that A.M. Best gives Golden Rule gives consumers cause for alarm.

In 1993, A.M. Best gave Golden Rule an A-plus saying that since 1989 the implementation of rate increases, the raising of deductibles and marketing limitations on certain group health coverage has returned operating results to a profitable status during each of the past 4 years. This profitability is attributable to the company's careful underwriting, its sophisticated claims system and its adequate rate increases. In other words, Mr. Chairman, Golden Rule is doing well financially by charging high rates, denying applications and denying claims.

Other concerns that are raised by Golden Rule, again as an example of what other insurance companies are doing, are the following: First, we have seen examples of deceptive sales promotion practices. After we started investigating Golden Rule, we were contacted by an insurance broker from Indiana who told us that he will no longer deal with Golden Rule because of deceptive practicing. He said that several years ago in brochures promoting Golden Rule's inflation guard health care plan, the company stated clearly that emergency care services would be covered; yet when one policy holder with no previous claim sent in a claim for $118.50 cents for an emergency room visit, the company refused to pay stating that outpatient emergency care was excluded from coverage.

Other concerns include a history of rate increases in double digit and often more than once per year. Additionally, we are concerned about loss ratios which A.M. Best said in 1992 was 65 percent; others say that it may be as low as 40 percent in some States. That means that consumers are getting only 65 cents on the dollar and we are concerned about how that other 35 cents is being spent.

In earlier testimony, you heard about problems with preexisting condition exclusions. Vermont has said that one out of four people covered by Golden Rule had such exclusions.

Being concerned about the complaints that we heard, Citizen Action in April wrote to every State insurance commission asking for information on Golden Rule and several other insurance companies. I must report that only five States were able to provide what we believe were relatively comprehensive responses. Nine States gave incomplete responses. For example, Washington State and South Carolina do not characterize complaints by insurance companies but only by complainant and insurance agent. Twenty-one States could not respond either because they failed to keep the information, did not have computerized systems, required significant payment for getting the information which unfortunately Citizen Action was unable to pay, required—were prevented from providing the information because it was confidential, or in the case of one State, "do not provide special interest-type reports." Fifteen States failed to respond.

However, I will say that a number of State insurance commissioners took the opportunity to call us and contact us and talk about what they labeled campaigns of intimidation against State insurance regulations and this is a very serious cause for consumer alarm.

On June 27, we wrote to Golden Rule asking for information on the company's practices. As of today we have received no response. We believe that since Golden Rule requires potential policyholders to provide it with extensive detailed personal information before writing a policy, it is only fair that Golden Rule provide consumers with detailed information about its performance.

In one case we got the application from the State of Ohio. Golden Rule had asked policyholders to give their complete medical history for the past 10 years and in addition asked that it be able to obtain any information that they needed to underwrite or verify the application for life or health insurance. "Any person having information as to a diagnosis, the treatment or prognosis of any physical or mental conditions of me or my family and any non-medical infor-

mation about me or my family is authorized to give it to any of the above parties;" that is Golden Rule.

In short, individuals seeking to obtain basic health care coverage, Golden Rule requires that applicants provide the most personal, private medical and non-medical information. Once that information is obtained, Golden Rule can use it to deny coverage to individuals, increase premiums, copayments and deductibles, deny claims or cancel policies.

Mr. Chairman, the type of information that we were requesting from Golden Rule is extremely important to consumers in terms of selecting policies and then knowing whether they are getting their money's worth. Among the information requests that we asked were denial rights for applications, denial rights for claims, administrative costs, record of premium increases, record of policy cancellations, marketing costs, utilization of review protocols; in other words, where a utilization review is performed who does it, what their qualifications are, how determinations of necessity and appropriateness are made.

In our investigations into the practices of other insurance companies, we have found that the ability to decide what is a valid claim, what is a medically-necessary treatment is being used by companies to profit on the backs of consumers, denying them the health care that their providers believe that they need.

In the instance of Humana, for example, we were able to obtain their protocols from someone who had written those protocols and subsequently became disillusioned with them, where people were encouraged not to read the fine print to consumers about what could be excluded, where medical necessity was called a gold mine so that companies could deny claims and make money; this is a very important issue for consumers.

Additionally, we asked for information on grievance procedures, the salaries and benefits of company executives, so we could see where that 35 percent of every dollar was going to, the length of waits to obtain appointments. This is the type of information that we need if we are going to allow private insurance companies to continue to run the health care system.

As I said, we don't support that, but if we are confronted with that, you can be assured that Citizen Action will be doing everything possible to obtain that type of information. We are extremely gratified that this subcommittee is working in the same vein and we encourage you, although I am not sure you need encouragement, Mr. Chairman, to continue to work to get that information to ensure against intimidation by private insurance companies, either against State regulators or consumers who seek to challenge them and to ensure that consumers' health care dollars are well-spent.

Thank you.

[The prepared statement of Ms. Hurwit follows:]

Statement of

Cathy Hurwit
Legislative Director
Citizen Action

Mr. Chairman and Members of the Committee, we very much appreciate the opportunity to testify today on the failure of the health insurance industry, in general, and the Golden Rule Insurance Company, in particular, to provide Americans with reliable, affordable comprehensive health care coverage. We applaud your effort, Mr. Chairman, to investigate and expose health and insurance industry abuses that bilk consumers out of billions of dollars every year, that leave millions of consumers without adequate coverage and that undermine state regulation, which is usually not very strong to begin with.

While we recognize that there are many facets to the health care crisis in America today, none is more pronounced, none is more damaging to the health and welfare of our nation than the existence of 39 million of our fellow citizens, many of them children, who are uninsured and the 60 million more who have inadequate insurance.

We would not have the type of health care crisis we have today, if we had an insurance system that covered everyone regardless of age, sex, health status, employment status, and geographical location. Instead of spreading risk across a large, diverse population in the traditional fashion of the insurance industry, most health insurance companies today seek to avoid financial risk through "cherry picking" -- only insuring individuals and groups of individuals who are young and healthy and excluding those who are old or sick. And despite screening out individuals with potentially higher health care costs, Golden Rule is still worse than other insurers when it comes to paying out benefits.

One of the leading advocates for this perverse selection process is the Golden Rule Insurance Company, the nation's largest seller of health insurance to individuals. Golden Rule is a pace-setter among the nation's commercial health insurance companies. This company's business mantra is to attract usually young, unwitting consumers with policies that have low front-end costs, but which over time become either very expensive or very limited in what coverage they actually provide.

To attract policyholders, Golden Rule has engaged in deceptive promotional practices, and to weed out those that pose the company financial risk, Golden Rule uses medical underwriting, utilization review and other bureaucratic schemes that deny coverage and benefits to consumers. Such practices, while profitable for Golden Rule and other companies, are extraordinarily wasteful and costly to consumers and medical providers. While promoting itself in big print as a provider of low-cost health insurance, the small print of the company's

policies reveals quite a different picture – one that should raise real concern about relying on the marketplace to provide affordable health insurance to all Americans.

Golden Rule is the largest writer of individual health insurance in the country. In fact, most individual policies, even those sold under the name of other insurance carriers, are usually Golden Rule's. It conducts nearly 44% of its business in five states: Illinois (12.4%); Texas (10.4%); Ohio (8.4%); Florida (7.5%); and Connecticut (5.2%). There are Citizen Action organizations and members in all five states.

In 1993 A.M. Best rated Golden Rule A+ (Superior) in part because of its strong profitability and its strong market niche in the health insurance field. Since 1989, according to A.M. Best, "the implementation of rate increases, the raising of deductibles and marketing limitations on certain group health coverage has returned operating results to a profitable status during each of the past four years...This profitability is attributable to the company's careful underwriting, its sophisticated claims systems, and its adequate rate increases." In other words, Golden Rule is doing well financially by charging high rates, denying applications and denying claims. It is also interesting to note that the June 1989 issue of *Consumer Reports* found that "Golden Rule has the toughest standards, rejecting 20 to 30 percent of all applicants who are 65, and *as many as 50 percent of those who are 70.*"

Because it is the largest insurer of individuals, the company is in a pre-eminent position to threaten state regulators telling them that if they don't provide the rate increase sought by the company, they will pull out of the state leaving thousands of people uninsured (and probably uninsurable, since so few other insurance companies sell individual policies). Leaving policyholders without insurance does not seem to bother the executives of this company. Perverting the charitable principle of the Golden Rule, the leaders of this company operate on the basis of he who has the gold rules.

Obtaining and Providing Information

On June 27, we wrote to the chairman of Golden Rule, Mr. J. Patrick Rooney, to obtain information on his company's practices. As of today, we have received no response from Mr. Rooney or a representative of his company. Since Golden Rule requires potential policyholders to provide it with extensive, detailed personal information before writing a policy, we thought and continue to think it only fair that Golden Rule provide consumers with detailed information about its performance. In the State of Ohio, for example, Golden Rule asks potential policyholders to provide information on their medical history covering the most recent 10-year period. Golden Rule also asks whether an individual "has had any indication, symptoms, diagnosis or treatment of any disease or disorder" for a whole range of conditions

including such common ones as pregnancy, back pain, asthma and sinus problems. In addition, the company requires potential policyholders to provide it with the name of every doctor consulted within the most recent 5-year period. Anyone seeking individual or small group coverage must not only provide answers to questions on their 10-year medical history, but also authorize the company, its reinsurers and its representatives

> ...to obtain information that they need to underwrite or verify [my] application for life or health insurance. Any person having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions of me or my family and *any nonmedical information* (emphasis added) about me or my family is authorized to give it to any of the above parties. This includes information related to substance use or abuse. The persons that are authorized to give this information include any doctor or other practitioner of the healing arts, hospital clinic, other health or health related facility, pharmacy, the Veterans Administration, employer, Medical Information Bureau, or insurance company that may have such information.

In short, for individuals seeking to obtain basic health coverage, Golden Rule requires applicants to provide the most personal private medical and non-medical information. Once this information is obtained, Golden Rule can use it to deny coverage to individuals, increase premiums, co-payments and deductibles, deny claims, and cancel policies. No matter what happens, whether the company writes a policy or not, Golden Rule will always have access to that personal, private information.

Although Golden Rule obtains very detailed information on potential policyholders, it provides very little information to potential policyholders when they apply for health insurance coverage. For example, although the company proudly announces the company's A.M. Best rating to indicate its financial strength, a consumer reviewing application materials to determine whether to apply as a policyholder is unable to learn the following pieces of critical information:

- denial rates for applications
- denial rates for claims
- administrative costs
- record of premium increases
- record of policy cancellation
- marketing costs
- utilization review protocols -- where is utilization review is performed, who does it, what are their qualifications, how are determinations of medical necessity/ appropriateness made
- grievance procedures
- salaries and benefits of company executives
- length of waits to obtain appointments with Golden Rule PPO providers

Furthermore, while Golden Rule reports on the number of employees it has, it does not report precisely how many are employed to do underwriting, what they are paid and how much Golden Rule actually spends to deny people coverage. Consumers do not know how quickly and completely Golden Rule pays its claims. Consumers do not know the ownership structure of the company or the extent to which it engages legions of lawyers and other professionals to prevent state insurance regulators from limiting premium increases. Consumers do not know how much Golden Rule spends on lobbyists at the state and national level to obtain favorable treatment or to prevent passage of pro-consumer legislation.

As part of its investigation, we urge the Subcommittee to determine the extent to which premium dollars are being spent on matters unrelated to providing insurance. For example, how much of the 35 cents not paid out in benefits, goes to fund the National Center for Policy Alternatives, or on ads opposed to state health care reform proposals, or to campaign contributions at the local, state and national level.

Deceptive Sales Promotion Practices

In promoting the sale of their health insurance policies, some companies fail to truthfully describe limitations of benefits. In Indiana, for example, one insurance broker, who no longer will deal with Golden Rule, explained to us that several years ago in brochures promoting its "Inflation Guard" health care plan, the company stated clearly that emergency care services would be covered. Yet, when one policyholder with no previous claims sent in a claim for $118.50 for a visit to a hospital emergency room, the company refused to pay stating that, according to the policy, out-patient emergency care was excluded from coverage.

Most consumers seeking individual policies are not equipped with sufficient information about insurance company practices and performance to determine if companies like Golden Rule are engaged in deceptive or misleading practices. It is only after the fact, after a policyholder has written the premium check or checks and then tries to collect on a benefit that what was promised in bold-faced type of the sales brochure may not be the same as what is contained in the small print of the policy. Because most states do not have the staff or resources to police those practices, it is not surprising that insurers like Golden Rule often take advantage of uninformed consumers.

Raising Rates and Profits

Golden Rule, like other commercial insurance companies, seeks to increase its share of the health insurance policy market by attracting young, healthy people with initial low monthly premiums. However, as some of these young, healthy policyholders begin to get

sick, companies often jack up rates. In response, those who are still healthy, leave and purchase another low-cost policy while those who are sick either remain and pay the higher rates, because they are unable to obtain other health insurance, or drop coverage altogether. Yet, incredibly, as claims increase, so do profits. This is because premiums are determined by the minimum loss ratio method which results in a cost/plus system for determining premiums. As was pointed out in previous testimony to this subcommittee, Golden Rule in 1992 had a loss ratio of 65. Assuming claims were $1,000, then the maximum premium would be $1,538. The $538 difference between premiums paid and claims is the money that goes to administrative expenses and profit. If, however, claims doubled to $2,000, then so too would the premium and the money going to administration and profits even though administrative expenses may not have risen at all. Under this kind of cost/plus system, instead of being the lowest cost insurer over time, Golden Rule becomes the highest cost. In Florida, for example, Golden Rule's average annual premium rate increase was 45% compared to an increase of 21% for Blue Cross. After 4 years, a $1,000 annual premium was $4,490 for Golden Rule, but only $2,134 for Blue Cross.

Exclusions and Shifting Risk to Policyholders

In addition to sharply increasing premiums to policyholders, many health insurance companies use a technique known as exclusion to limit corporate risk. Also, in previous testimony to this subcommittee, the Director of Insurance Regulation for the State of Vermont cited a study on exclusions done by Blue Cross and Blue Shield after Golden Rule left the state following passage of a health care reform law that required community rating (charging all members of a defined community such as a state the same premium rate for the same coverage over a defined period of time) . The study found that 25% of Golden Rule policyholders had separate exclusions added to their policies. In the case of a self-employed commercial painting contractor with no history of back problems, for example, Golden Rule excluded any loss "resulting from any injury to, disease or disorder of the spinal column, including vertebrae, intervertebral discs, spinal cord, nerves, surrounding ligaments and muscles, including complications therefrom or operation therefor." So much for comprehensive coverage.

Three years ago Citizens Fund issued a report, "The Seven Warning Signs: Health Insurance at Risk" which determined that there are 81 million people under the age of 65 who have health care problems that could result in their facing those types of exclusions. We found, for example, that insurers, like Golden Rule, are refusing to cover people with medical conditions as common as diabetes, asthma, headaches,allergies and pregnancy.

Intimidation and Litigation

Aside from shifting risk, cost and responsibility to its customers, Golden Rule and its chairman, Mr. J. Patrick Rooney, have carried on campaigns of intimidation against state insurance regulators whose job it is to protect consumers from unscrupulous, improper and illegal activities of insurance companies.

Golden Rule regularly intimidates, threatens and blackmails state insurance regulators in order to obtain higher rate increases, despite the fact that it only provides 65¢ in health care benefits for every dollar in premiums it collects. Golden Rule's antipathy to regulation is underscored by the following partial list:

7

- In 1988 in Massachusetts, Golden Rule refused to market through independent brokers when action was delayed on a rate increase request.

- In the 1990 election, Golden Rule spent over $1 million in independent expenditures to try to defeat the Florida Insurance Commissioner, because the Commission had objected to Golden Rule's cancellation of major medical policies for 20,000 Florida policy holders.

- In 1990 in North Carolina, Golden Rule requested a 73% increase in the first quarter, and then a 20% rate increase the next quarter. Since state law allows but one increase per year, Golden Rule was denied. The company threatened to pull out of the state and leave thousands without insurance. The company mailed every insurance agent and policyholder announcing it was pulling out of North Carolina due to the Commissioner's decision. After a press conference on the subject held by the Commissioner, Golden Rule sued for slander. The company eventually lost the case.

- In August 1990, Consumer Reports cited Golden Rule as one of the worst insurance companies: "Some companies no longer offer low deductibles. 'If somebody can afford to buy our product, he can afford a $1000 deductible,' says John Hartnedy, the chief actuary at Golden Rule. 'You don't want first-dollar coverage. It may cost $80 to take care of a $50 bill.'

- A few months ago Golden Rule began a public relations blitz in Wisconsin in

an effort to defeat health care reform legislation by claiming that customers would see major rate increases, perhaps as much as 200 percent. The State Insurance Commissioner, a former nurse, announced that her office would require Golden Rule to verify its claims.

Some other examples include:

- filing for multiple rate increases in one year

- marketing a universal life policy with 12% interest but failing to mention the expense charges involved

- selling low cost Medicare supplement policies in Florida and then jacking up the premium. The insurance commissioner ran ads criticizing Golden Rule's "bait and switch operation."

In addition, Golden Rule is a frequent litigant. Courts in North Carolina and Florida rule against Golden Rule when it charged the states' insurance commissioners with defamation and discrimination after adverse rulings. Golden Rule has often been found by courts to have dealt in bad faith with policyholders. In Golden Rule v. Hughes, in insurance agent told a policy applicant that she needn't disclose her full medical history. When her claim was denied by Golden Rule, the company said that the agent had acted improperly; the court said Golden Rule's argument was without merit. In Settles v. Golden Rule (a case dismissed on other grounds) the court found that the policyholder's death from a heart attack was a direct result of the termination of his insurance coverage. In another case, Golden Rule tried to sue a Missouri policyholder in Illinois (the state in which the company's main office is located) even though the policyholder had never had so much as telephone contact about the policy with anyone in Illinois.

In Tate v. Golden Rule, a particularly egregious example of claim denial, Golden Rule's physician testified under oath that he had examined a patient's x-rays and determined that her condition was a pre-existing one for which Golden Rule would not pay. In fact, the doctor had never seen the x-rays. The court ruled that Golden Rule's refusal to pay the medical bills was "vexatious," willful and without reasonable cause.

Another example of Golden Rule's malevolent treatment of consumers is Swader v. Golden Rule. An insurance agent and an independent insurance broker, relying on information provided by Golden Rule, offered city employees a Golden Rule health insurance policy that included coverage of preexisting conditions. Applicants were first told to complete the "long form," which contained spaces for information about preexisting conditions. Golden Rule then instructed applicants to use the "short form," which did not request information about preexisting conditions. Golden Rule issued the policy but city employees were not informed until several months later, after some of them had incurred medical bills for preexisting conditions. Golden Rule accepted premiums from the city but later claimed in a lawsuit that the sales agent and broker were not acting on its behalf. The court ordered Golden Rule to pay the medical bills in question. Clearly, consumers have a right to expect better treatment from a company which they have entrusted to provide them with health security.

As part of a systematic pattern of intimidation, Golden Rule accused the North Carolina Commissioner of Insurance with defamation, intentional interference with contractual relations and violations of the Unfair Trade Practices Act after Golden Rule was awarded a 50% rather than a 73.6% rate increase and Blue Cross/Blue Shield then agreed to provide comparable coverage. The court said that the allegations were unsupported by law or fact.

Medical Savings Accounts

Golden Rule's chairman is a well-known face on Capitol Hill. Those supporting Medical Savings Accounts or Medical IRA's look to J. Patrick Rooney as the head cheerleader for that pernicious proposal. On its face, like many of Rooney's insurance schemes, the Medical IRA sounds great. Upon close examination, it is a prescription for sabotaging the very basis of insurance. The basic concept of insurance is shared risk -- many pay premiums while a few account for the costs. Since one cannot predict one's own future health status, one obtains health insurance to protect against the possibility. In reality, only a small percentage of any large population accounts for the bulk of health care expenditures. Thus, the predominantly healthy pay for those who get sick. This is the way insurance works -- whether it is health insurance, homeowners' insurance, or car insurance. What Rooney is proposing individualizes insurance thereby removing the money that would pay to cover those who get sick. John Burry, Jr., the chairman and chief executive officer of Blue Cross & Blue Shield of Ohio has written that the Medical Savings Account idea is a "poorly conceived solution that would seriously undermine our nation's health care -- and potentially the health

of our nation." Berry goes on to analyze how Medical Savings Accounts would create "a large financial shortfall that would bankrupt our health care system," because they would remove the funds to cover the health care needs of those who need it most.

In addition to promoting a health care disaster like Medical Savings Accounts, Golden Rule has repeatedly demonstrated that it cares less about consumers and policyholders than it does about increasing its profitability. Golden Rule has a history of opposing state and federal actions which could lower its profits -- e.g. state insurance laws, state health care reform, catastrophic -- while at the same time supporting measures which will increase profitability and increase costs to consumers. For example, Golden Rule has set up a managed care system, "Physician Select." We encourage the Subcommittee to explore whether Golden Rule is engaged in redlining providers who have patients with higher costs. We also urge the Subcommittee to investigate the different payment rates in very high deductible plans and plans which have reasonable consumer cost-sharing.

Thank you again, Mr. Chairman, for providing me with the opportunity to testify today. Clearly, Golden Rule is a blatant example of why Citizen Action supports a single payer system which restricts the role of insurance companies which provide little of value to consumers. If, however, insurance companies are allowed to continue, they must be regulated with far more vigilance than they are today. Consumers, not just individual policy applicants and policyholders, but organizations like Consumers Union and Citizen Action, must have full and fair access to relevant information about these companies. We must ensure that policyholder dollars are well spent in paying for legitimate health care costs, rather than underwriting, arbitrary claims denials, political pressure and frivolous lawsuits against regulators trying to do their jobs. We believe that this Subcommittee is going in the right direction and would like to work with the Members of the Subcommittee on the issues you are examining.

Mr. DINGELL. Thank you, Ms. Hurwit.

The Chair recognizes the gentleman from Colorado.

Mr. SCHAEFER. Thank you, Mr. Chairman.

Ms. Hurwit, your organization wrote a letter dated 27 June 1994 to J. Patrick Rooney, Chairman of the Golden Rule, criticizing the company for its failure to provide to prospective policyholders critical information regarding Golden Rule's health insurance coverage. The letter asked Mr. Rooney to disclose to the public the company denial rates for applications and claims, as well as premium increases and policy cancellations. You indicated that you received no response to this letter.

To your knowledge, has Golden Rule made any efforts as a result of your letter to provide more public disclosure at all?

Ms. HURWIT. I am unaware of any such efforts, Mr. Schaefer.

Mr. SCHAEFER. According to a July 11, 1994 edition of the National Independent Underwriters, Mr. Rooney is quoted as stating your letter is part of a political attack, citing "Citizen Action is simply an actor for the administration."

Ms. HURWIT. Are you talking about the Clinton administration?

Mr. SCHAEFER. Yes.

Ms. HURWIT. That is very far from the truth. We are not supporters of the Clinton administration health care bill, if that is what the implication is. We have been and remain supporters of the McDermott single-payer bill that was introduced in the House. We took this opportunity to try to obtain information from the State regulatory agencies and from Golden Rule because we believe that we bear a responsibility to our members and to other consumers to try to protect them against unfair insurance company practices. This had nothing to do with the Clinton White House. We have never discussed this issue with anybody in the administration or any of the Federal agencies.

Mr. SCHAEFER. In the National Underwriters article, Mr. Rothchild, speaking for Citizen Action, said that we know from court records and State insurance commissions that Golden Rule has a history of denying legitimate claims, submitting huge premium rate increases and paying lobbyists to oppose legitimate State regulation.

I would like to have you expound on that.

Ms. HURWIT. We did, and you will see it in my testimony, we did a computer search in terms of cases which have been adjudicated, and you will see that some of those are listed—I have the page here—at the end of the testimony on page 9, Golden Rule versus Hughes, Settles versus Golden Rule and Tate versus Golden Rule, that is one of the things that we did and so as we know that most consumers who have been denied claims do not seek to go to litigation over them, we felt that this was the tip of the iceberg.

We have also seen plenty of evidence of Golden Rule's expenditures on Federal legislative issues such as catastrophic in the current national health care debate, and State legislative issues such as the Wisconsin insurance reform bill and Vermont. We are not saying that Golden Rule does not have a right as a company to try to affect legislation. That is their role.

What we are concerned about is whether, and if so, what amount of consumer dollars, policyholder dollars are going towards those

efforts. We do not think, and as a policyholder myself although not with Golden Rule, I don't think my premium dollars should be used by an insurance company to engage in political lobbying on an issue which I may oppose. I would like to see my health care dollars coming back to me in health care services.

Mr. SCHAEFER. Some States have laws which freeze their premium rates, and therefore over a period of 2 or 3 or 4 or 5 years, these providers cannot increase their rates.

Now, if I am not mistaken on this, when a 2- or 3-year period has passed, then they can increase their rates and they have to kind of catch up to whatever the increased health care costs are. Have you taken that into consideration?

Ms. HURWIT. Yes, we have looked at that. I am not about to appear before you and tell you that a specific rate increase request is legitimate or not legitimate. I can tell you that based on our investigations into this, Golden Rule does not have a practice of waiting 2, 3 or 4 years before asking for a rate increase. You have heard about that from some State regulators already and may hear from others following that.

The issue from the consumer perspective is if in fact any insurance company goes in and asks for a rate increase, obviously we do not want to deny a rate increase which is legitimate. The question is: do we have the information as consumers and policyholders to know whether those requests really are legitimate. I get back to the issue of where is the money—including not being paid in terms of health services—going to? Is it going to lobbying, campaign contributions, political message, commissions, underwriting and claims review that can be streamlined and reduced? That is the consumer issue.

Mr. SCHAEFER. One final question, Mr. Chairman. In quoting Mr. Rothchild, paying lobbyists to oppose the legislation now, I would like to hear what that means. I mean, I know about hundred dollar bills and all that, but is that what it is all centered on in that one instance?

Ms. HURWIT. I am trying to understand your question. Are you——

Mr. SCHAEFER. Mr. Rothchild said, "We know from court records and State insurance commissions that Golden Rule has a history of denying legitimate claims, submitting huge premium rate increases and paying lobbyists to oppose legitimate State regulation." What does that mean; the last one?

Ms. HURWIT. Mr. Schaefer, I do believe that policyholders have a right to know if their premium dollars are being used——

Mr. SCHAEFER. I am talking about paying lobbyists to oppose the legitimate State regulation and then therefore the lobbyist money going to individual legislators.

Ms. HURWIT. Well, there are two separate issues here, one of which is whether premium dollars are being used to furnished lobbying and campaign contributions.

Mr. SCHAEFER. Cross subsidization.

Ms. HURWIT. I am a paid lobbyist. Although I must admit I think I probably make significantly less than the salary paid to Golden Rule's lobbyist, I have nothing against paid lobbyists Mr. Schaefer. My concern is are the people who have paid money to Golden Rule

with the expectation that those dollars are going to come back to them in health care services funding lobbyists to go forward at the State or national level to represent Golden Rule's position, which very likely may not be the position of the policyholder, and I think that is a very legitimate question for consumers to be asking.

Mr. SCHAEFER. So basically paying lobbyists is not a problem?

Ms. HURWIT. It is America; it is the right that everyone has. I would like to see some sort of evening of the playing field so that those of us in the public interest sector have some sort of an equal opportunity here, but that is a different issue and we may be able to discuss that at another time. The issue here today is whether policyholders should be funding the efforts of Golden Rule or any other insurance company to engage in those practices and, frankly, if when Golden Rule goes in for a rate increase, I think it is a fair thing for consumers and State regulators to know whether the rate increase is at least partially being requested in order to fund those activities.

Mr. SCHAEFER. One final thing. In Colorado, for example, the majority of the insurance companies were very supportive and helpful in obtaining the passage of health insurance reform legislation. How does Golden Rule stack up with other companies in your estimation?

Ms. HURWIT. In terms of in lobbying work or in terms of their provision of health care——

Mr. SCHAEFER. In terms of their lobbying work. We know that all insurance companies do that.

Ms. HURWIT. Let me say, I was going to say that I think the insurance companies don't need any help from us in terms of knowing how to lobby. They do it very well and they spend a great deal of money on it.

Mr. SCHAEFER. As do many other organizations.

Ms. HURWIT. I would take a tenth of what they spend on their lobbying efforts to fund the consumer effort on health care. We can discuss this in great depth if you would like. It is very frustrating for people in the public interest to deal with—the word that comes to mind is the "hordes" of insurance company lobbyists and lobbyists for other large businesses in the health care industry. It is very hard for us to confront that.

Again, I am not saying that companies should not be able to hire lobbyists. I am not saying that companies shouldn't be able to take up political advertising. The point here today is whether policyholders should be paying for it.

Mr. SCHAEFER. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair thanks the gentleman and the Chair recognizes the gentleman from Texas, Mr. Barton.

Mr. BARTON. Mr. Chairman, since I didn't get to hear the gentlelady's opening statement I don't think it would be appropriate for me to have a question at this time, but I appreciate the opportunity.

Mr. DINGELL. Very well. The Chair recognizes himself.

You describe in detail matters which you regard as egregious about Golden Rule, its relationship with regulators, and actions which you indicate have been used by that company to undermine the ability of regulators to fairly and properly protect the interests

of consumers. Would you please describe those matters in greater detail, please?

Ms. HURWIT. Well, certainly. There are a number of instances that we have heard about where—in which Golden Rule has, in our view, intimidated, threatened and actually blackmailed State insurance regulators. One of the ways that they are able to do that is because they are the largest writer of individual policies. The threats to withdraw from a State or market area can be fairly serious.

Some of the things, and you will see it on page 8 of my testimony, some of the events that we have heard about, going back to 1988, Golden Rule in Massachusetts refused to market through independent brokers when action was delayed on a rate increase request. In 1990, Golden Rule spent over a million dollars in independent expenditures in Florida insurance commissioners rates, in part because the commission had objected to Golden Rule's cancellation of major medical policies. In 1990, in North Carolina Golden Rule requested a 73 percent increase in the first quarter, then a 20 percent rate increase the next quarter. That increase was denied.

The company then threatened to pull out of the State and leave thousands without insurance. Those are several—you have also heard about the public relations splits in Wisconsin in which Golden Rule spent a great deal of money in order to defeat health care reform legislation.

Those are some of the examples, Mr. Chairman.

Mr. DINGELL. You mentioned the business of pulling out of a State. Can you describe the process in greater detail that you have discussed in which Golden Rule will indicate to the authorities or the regulatory agency in the State that it will abandon thousands of policies of citizens when it fails to get what it wants from the State regulators?

Ms. HURWIT. What we have heard from the different insurance commissions is that this is a very common practice and that what they are trying to do is essentially hold up the insurance commissions saying that if they don't get the rate increases that they would like they will leave and go market somewhere else.

Mr. DINGELL. Now, I am curious—how does this business of withdrawing from a market, abandoning policyholders, translate to protecting the best interests of the policyholders?

Ms. HURWIT. Well, I don't believe it does. I think it really puts consumers between a rock and a hard place in which individual consumers and small groups are typically unable to find any coverage. When they are able to find some coverage, even if it is incomplete protection, as some of the policies which Golden Rule offers, they want to try to hang onto it. If, in fact, the choice is dealing with rate increases or having no insurance at all, many individuals and small groups will be forced to pay the higher prices in order to have some coverage and to guard against financial catastrophe as a result of serious illness or injury.

Mr. DINGELL. Ms. Hurwit, you said in your testimony most companies today seek to avoid financial risk through cherry picking, only insuring individuals or groups of individuals who are young and healthy and excluding those who are old or sick. Despite

screening out individuals with potentially higher health care costs, Golden Rule is still worse than other insurance when it comes to paying out benefits.

Can you describe, first of all, the tactics that are used by Golden Rule and others to cherry pick the market and then tell us the consequences to the health care system that results from this kind of activity?

Ms. HURWIT. The example that I gave in my testimony was the information we received when we applied for a Golden Rule policy, to get the materials to apply for a Golden Rule policy in the State of Ohio. In that, Golden Rule had a long litany of questions that they asked about the medical history of the applicant, including whether they had back pain, information as to whether they had asthma or sinus problems or pregnancy and then had an open-ended request for medical and non-medical information so that the company could analyze whether they wanted to enroll that individual or small group as policyholders.

That is the first step in the process. Obviously, what we have found in another study that Citizens Fund, which is our research affiliate, undertook is that 81 million Americans have those types of health care problems that could exclude them from coverage under Golden Rule's techniques or could subject them to higher premium costs or preexisting condition exclusion.

So what happens is even if you then make it through the gauntlet of this type of medical history inquisition, you then face another gauntlet, the question of any time you need health care services whether Golden Rule will decide whether those are valid or legitimate or medically necessary. One of the concerns we have is that since they are not taking all comers, why they have a consumer payout of only 65 percent, and in some of the States that have testified before you, even lower than 65 percent.

Mr. DINGELL. You have also mentioned that Golden Rule makes extensive requests for information from its policyholders. You have also advised that Golden Rule provides scant information about itself in return. What is the bare minimum of information that Golden Rule should be providing to its policyholders that it is currently not providing?

Ms. HURWIT. I think that the list that we requested from Mr. Rooney, and which is on page 4 of my testimony, is what we would think a bare minimum is. The most important issue for consumers is where their premium dollars are going so there are a series of questions in terms of how much of the premium dollars is going for administrative expenses, marketing costs, utilization review, underwriting, salaries of the CEO's, if any of it is going towards political message advertising and lobbying. That is one question.

The second question is if you are an enrollee in a Golden Rule plan, what is the likelihood that your health care needs are going to be met? That gets to the question of how long you have to wait for appointments in their networks and managed care plans, what utilization review practices they use, what their denial rates are, whether there have been any complaints by physicians that their treatment decisions have been overturned.

Mr. DINGELL. Why did Golden Rule object to providing this kind of information to its policyholders?

Ms. HURWIT. I can only surmise that if policyholders knew about some of the answers, they might either choose to go elsewhere if they could or to demand increased regulation at the State or Federal level.

Mr. DINGELL. In Missouri, they sued to keep the insurance department's market conduct exam from being made available to the public. Why would they have done that?

Ms. HURWIT. Mr. Chairman, I can only surmise that they may have felt if their policyholders or potential policyholders knew, then they would demand action or go elsewhere.

Mr. DINGELL. Golden Rule, as you know, is very diligent in protecting their interests and they assert that this is associated with the constitutional protections, rights of citizens to be protected from government intrusion. Yet you bring up a point which seems to be at odds with that. For individuals seeking to obtain basic health coverage, Golden Rule requires applicants to provide personal, private medical and non-medical information. Once this information is obtained, Golden Rule may use it to deny coverage to individuals, increase premiums copayments and deductibles, deny claims and cancel policies. No matter what happens, whether the company writes a policy or not, Golden Rule will always have access to that personal private information. We seem to have two views or two situations at hand.

On the one hand, Golden Rule cloaks itself in the effort to protect its rights, but here we talk then about the corporation that requires everything from its policyholders about their families, themselves and their family tree, but doesn't give the kind of information you said that an informed consumer requires.

What comment do you have on that?

Ms. HURWIT. Two comments. The question about obtaining personal history, medical history of applicants is certainly clear with Golden Rule. It is also occurring with other insurance companies. I just met with some physicians from Chicago this past weekend who were telling us that they are being queried by insurance companies not just about actual treatment but any phone conversations that they may have had with patients or other doctors about treatment decisions, so this is a widespread problem.

My comment, Mr. Chairman, generally, however, goes back to a saying that a former boss of mine who served on this committee used to say and that is "You can't blame the lions for eating the gazelles." Golden Rule is doing what is in Golden Rule's best interests. Unfortunately, it is not the interest of the gazelles, in this case the consumers, and I think the consumers are looking for some protection against the lions.

We are very happy that the subcommittee is stepping forward to provide some of that protection and to get some of that information. It is desperately needed.

Mr. DINGELL. The time of the Chair has expired.

The Chair recognizes the gentleman from Ohio.

The gentleman from Colorado.

The gentleman from Texas.

Mr. BARTON. One question, please.

Mr. DINGELL. Of course.

Mr. BARTON. I thank the Chair.

My question would deal with the coverage or lack thereof of acquired immune deficiency syndrome, commonly called AIDS. I am told that Golden Rule doesn't require a blood test for AIDS. Is that your knowledge or not?

Ms. HURWIT. That is my understanding.

Mr. BARTON. I am also told that Golden Rule has one of the quickest payout rates for that disease once it is—once there are claims made; is that correct?

Ms. HURWIT. Frankly, I would not know because the company has refused to give us the information on payout rates. Moreover, I would ask whether those are payout rates for claims which the company has decided are valid or legitimate or whether those are claims submitted. But we have no way of knowing because that information was unavailable to us both at the State regulatory level and through Golden Rule itself.

Mr. BARTON. It would tend to me to indicate that perhaps they are not the demons that they are made out to be since that is the one illness that has the highest incidence of cost once it is incurred and it is a terrible disease, at least in this particular disease, it doesn't—the facts don't seem to paint the same picture that you attempted to paint in other areas.

Ms. HURWIT. Actually HIV is not the most expensive disease, unfortunately, because most people do not survive that long once they incur it. But there are many questions I would have in this area.

I understand that Golden Rule has adopted a physician select program for its managed care network. We have seen with managed care companies deciding which providers to let into their network, they have done it on the basis of whether physicians serve inner city low-income areas, whether they are gay, whether they have a gay clientele. So I cannot tell you that in this area Golden Rule is a model citizen because there are many, many questions that are left out.

I can tell you, however, that on the basis of the complaints that we have received from consumers, insurance brokers and State regulators, that Golden Rule is far from serving as a model of social responsibility.

I will say—and this was my comment earlier—that we do not expect Golden Rule to operate in that manner. They are out to make a buck, and as the quote from A.M. Best demonstrates, they are doing quite well at that. Our question is whether they are serving their policyholders and the public.

Mr. BARTON. But you do confirm they don't require a blood test for applicants——

Ms. HURWIT. I have heard that. I cannot confirm that. There are many things that we would like to know the answer to if we could get the information from the company.

Mr. BARTON. I thank the chairman.

Mr. DINGELL. The Chair thanks the gentleman.

Ms. Hurwit, can you describe in greater detail the matters that you discussed in your comments about what Golden Rule does to limit the ability of regulators to fully and properly protect the interests of the consumers?

Ms. HURWIT. Well, I think that this is, unfortunately, a two-edged sword. One of the things that we have found through our

survey of State regulators is that many State insurance departments are understaffed and are unable to do the type of investigatory digging that I think is required to look into the practices of a company like Golden Rule.

I also believe that Golden Rule has not been forthcoming in terms of providing that information either to State regulators or to consumers. The threat of intimidation when you do control a large share of the individual or small group market in an area, the threat of pull-out, I think is a very serious one.

There are State insurance commissioners who have been very courageous in terms of standing up to Golden Rule, but I think it is a very hard thing to do when you are given these two choices, what do you do in the absence of any kind of insurance coverage at all.

Mr. DINGELL. You mentioned in your testimony that Golden Rule regularly intimidates, threatens and blackmails State insurance regulators. Can you describe the methods that Golden Rule uses to accomplish this end?

Ms. HURWIT. Well, I must admit it was surprising to us to learn about the litigation which has been lodged against State regulators who we believe are just doing their job in terms of protecting consumers. The threat of litigation, the threat of pullout, the threat of getting involved in election campaigns I think are all examples of intimidation.

Mr. DINGELL. Are their further questions for Ms. Hurwit?

The committee thanks you for your very fine presentation to us today. We always appreciate your appearance before the committee.

Ms. HURWIT. Thank you, Mr. Chairman.

Mr. DINGELL. Panel two will be a panel composed of the Honorable Mike H. Coffman, State Representative, State of Colorado, P. O. Box 440740, Aurora, Colorado; Hon. Ernesto Scorsone, State Representative, State of Kentucky, First National Building, Suite 804, 167 West Main Street, Lexington Kentucky; Mr. Daniel Pitts Winegarden, First Deputy Insurance commissioner, Insurance Division, Iowa Department of Commerce, Lucas State Office Building, Des Moines, Iowa. Welcome.

All witnesses testify under oath. Do any of you object to testifying under oath?

That being so, you are entitled to be advised by counsel.

Do any of you choose to be advised by counsel during your appearance?

Copies of the Rules of the House, the Committee and the Rules of the Subcommittee are at the witness table to advise you of your rights and limitations on the power of the committee as you appear here.

[Witnesses sworn].

Mr. DINGELL. We will recognize you, Mr. Scorsone, Mr. Winegarden and Mr. Coffman. Gentlemen, you are recognized for your testimony.

Mr. SCORSONE. Mr. Chairman——

Mr. DINGELL. This committee room has without exception the worst public address system you will find. So you must make sure the thing is on and get close to it.

TESTIMONY OF ERNESTO SCORSONE, STATE REPRESENTATIVE, STATE OF KENTUCKY; DANIEL PITTS WINEGARDEN, FIRST DEPUTY INSURANCE COMMISSIONER, STATE OF IOWA; AND MIKE COFFMAN, STATE REPRESENTATIVE, STATE OF COLORADO

Mr. SCORSONE. Thank you, Mr. Chairman and members of the subcommittee. I am Ernesto Scorsone, State Representative from the Commonwealth of Kentucky. I am pleased to be here to address the issue of health insurance industry practices, particularly the Kentucky experience with the industry during our passage of health care reform legislation and even more particularly the practices of Golden Rule Insurance Company.

I come to you as a survivor of Kentucky's health care reform wars. After more than 18 months of hand-to-hand combat, our reform bill passed in April and became law last month. While it is true that wars and combat are not supposed to be pretty events or even civil encounters, certain codes of conduct exist that even the most war mongering nations subscribe to. That was not so with Golden Rule during the health reform battles in Kentucky. Their tactics were far from normal. Let me give you a flavor of the public comments that were made about Golden Rule.

The veteran respected chairman of our Senate Appropriations Committee said in an open meeting, " those people are liars." Our Human Resources Secretary, upon Golden Rule filing a lawsuit against our reform law, suggested the company name should be changed to "Golden Shaft." During my 10 years in the legislature, I have never seen a business entity incur so many disdain.

What would lead reasonable people in our State as genteel and as respectful of others as we are in the commonwealth to lambast this company with such vigor and zeal? I believe the answer lies to the response Golden Rule made to our efforts to improve Kentucky's health care system.

Our Health Care Reform Act of 1994 is a very progressive and comprehensive piece of legislation. This law encompasses the following: data collection on cost; quality and outcomes of health care providers; changes in our medical education to enhance the number of primary care practitioners as well as encourage more practitioners into rural areas; creation of a large consumer-controlled purchasing alliance to give consumers purchasing clout in the marketplace; Medicaid reform to streamline our program and promote more managed care; development of practice parameters and adoption of self-referral prohibitions; and last but not least, substantial health insurance reform.

Our insurance reform includes curtailment of preexisting condition clauses, guaranteed issue, renewability and portability, repeal of our loss ratio guarantee provision, standardization of insurance offerings and a modified community rate that does not allow rates based on sex or health status.

Those last items pose no problems for insurance companies who play by the rules and seek to distribute the risk fairly among enrollees. However, the reforms do threaten the insurance companies whose strategy has been to cherry pick in the marketplace, those companies who attempt to cover healthy people and avoid covering

the rest. Those practices will no longer be allowed in our State. The reaction to the reform efforts was fast and furious.

We saw well-financed, well-organized campaigns of disinformation, misinformation and outright deception. During the course of the debate, Golden Rule sent several doomsday letters to its policyholders, letters that purported to give alarming examples of certain dire provisions within the bill. That the examples were distortions seemed irrelevant. The letters achieved their goals, which was to spread fear and confusion.

Legislators received many a call from frightened senior citizens. One letter from Golden Rule to its policyholders said that our health reform proposal would raise individual rates 90 percent. I received calls from constituents who claimed to have been informed that either their coverage would end or that rates would skyrocket 200 to 300 percent as a result of reform. Not true, not based on any fact or evidence or even a remotely accurate reading of the bill under discussion. Nonetheless, scary figures guaranteed to stick in your mind, and that served the purpose of disinformation.

In a very telling manner, Golden Rule sent out Christmas cards this past year displaying what happy holidays meant to them. Let me show you this card. As you see, the gifts are neatly packaged here and they have little titles to these gifts and they say no community rating, no guarantee issue. How odd that anyone's joy and good cheer can come from discriminatory insurance practices and pricing policies that make health care unobtainable for those who needs it the most.

Incidentally, Golden Rule is not a large player in Kentucky's health care market. Their 1993 accident and health premiums were approximately $15 million, which translates to a little at over 2 percent market share. However, their 1993 complaint ratios, that is the number of complaints filed per $100,000 of net premiums, was well above the industry average. Their 12 percent complaint ratio was almost double the average in Kentucky.

Golden Rule also acted under another name, a newly formed and funded Council for Affordable Health Care Insurance. Letters the Council sent out were almost identical in approach and content to the Golden Rule literature and at times contained items identified as coming from Golden Rule.

Moreover, Golden Rule did not choose to play by our rules, rules governing ethical behavior by lobbying groups. Our Legislative Ethics Commission has filed an official charge against Golden Rule based in part on the company's refusal to disclose the money it spent on slick TV ads opposing the bill, which ran in our largest media markets. Golden Rule said it did not consider these ads to be lobbying efforts. One wonders what else they could have been.

Another little remarked upon effect of such an effort is its pernicious impact on the process itself. I would like to comment on that because we all know the legislative process is cumbersome at best. It threatens to collapse when the necessity to counter falsehoods is as time consuming as the work to agree on a bill. Legislative staff, as well as legislators, were bombarded with literature from Golden Rule and its affiliated groups.

Because of this and because serious constituent concerns were raised by the Golden Rule blitz, we spent long hours responding to

this propaganda. Almost daily we found ourselves fighting a rear guard action in committees on the floor and at home making point-by-point rebuttals of the latest outrageous Golden Rule claim. It was draining on those advocating reform and was effective for the opposition.

But to say nothing is to concede the point. So responses were prepared and delivered and this stressed the ability, I think, of staff and lawmakers to focus their energies on the task at hand which was defining and drafting the bill itself. It is hard to keep your eye on the ball when you are constantly swatting at gnats.

Nor are the battles over. Golden Rule has filed suit in Federal court challenging a reform claiming that in protecting consumers from unscrupulous and inequitable business practices we somehow violated the commerce clause and unlawfully infringed on their property rights. Only time will tell, but the State of Kentucky feels quite sure of its ability to successfully refute Golden Rule's claims.

In short, during the health care debate in Kentucky we saw political antics at their worst. Campaigns of fear and misinformation are wrong whether by elected officials, those seeking public office or those trying to influence the political system. I would hope that upon your Subcommittee's deliberations and work, you will contribute to reining in some shortcomings in the industry and help the consumer in today's market from being subjected to unscrupulous conduct.

Thank you.

Mr. DINGELL. Thank you.

Mr. Winegarden.

TESTIMONY OF DANIEL PITTS WINEGARDEN

Mr. WINEGARDEN. Thank you, Honorable Chairman Dingell and members of the Subcommittee on Oversight and Investigations. I appreciate the opportunity to appear before you today and to relate Iowa's story with regard to health insurance reform.

In particular, the subcommittee has asked for me to relate Iowa's experience with Golden Rule of 2 years ago, but more importantly to draw some lessons from that experience with regard to the efforts of Congress in setting appropriate health care reform objectives for the entire country.

Similar to the other two States at the table today, Iowa has been active in health care reform. We were early adopters and one of the original authors of the National Association of Insurance Commissioners Small Group Insurance Reform Act; one of the first States to fully implement it. We have proceeded with the creation of voluntary private health insurance purchasing cooperatives under public regulation and have a very actively reforming private market in Iowa.

Two years ago Iowa was engaged in small group reform and also in assuring that we protected existing authority to review insurance rates in the individual insurance market. Iowa is a preapproval State. That is, the insurance commissioner reserves the right to review insurance rates in the individual market to assure they meet three standards: first, that rates are not inadequate because we have a desire to protect the solvency of companies; second, to assure that rates are not excessive, that is, that there is

proportionality between the rates charged and the benefits to consumers; and that third, rates are not unfairly discriminatory, that they have a basis in statistical actuarial science and do not violate any of the specific restrictions of law and classifications.

Golden Rule opposed that rate review authority that the Iowa insurance commissioner had historically exercised and instead sought an insurance reform drafted by the company that would provide a minimum guaranteed loss ratio to exclude rate increases from insurance commissioner oversight and approval. This was originally raised during the 1991 session of the Iowa General Assembly, because it represented such a major departure from then-current practices of the Iowa insurance commissioner. We asked that it be deferred over session until a time to be studied between Golden Rule, the Iowa insurance commissioners office and members of the Iowa domestic industry.

This was the agreed-to procedure for resolution of the conflict. We agreed that if the division's concerns in protecting consumer interests could be successfully addressed and if a consensus of the Iowa domestic industry could be reached, that we would then consider the minimum guaranteed loss ratio provision.

That minimum threshold was not met. No work product was delivered to the Iowa Division of Insurance. There was no consensus. Instead, a month into the next session of the Iowa general assembly I received a phone call from Golden Rule's chief lobbyist, a gentleman by the name of Steven Bayer. He demanded the consent of the Iowa commissioner to Golden Rule's proposed minimum guaranteed loss ratio reform.

That proposed reform would provide that if the company delivered a minimum guaranteed loss ratio of 55 percent, that is, delivering 55 percent of total premium dollars back to consumers in health benefits, that rate increases would not be subject to review.

The lobbyist threatened to use whatever means necessary in lobbying and advertising to win its position in health care reform and to oppose the commissioner. A $500,000 figure was mentioned for the war chest, and I was also reminded of Golden Rule's history of suing insurance commissioners even in their personal status, not just in their professional capacity. I viewed this as an inappropriate threat and the pursuit of special advantage contrary to the best interests of Iowa consumers and Iowa companies.

We succeeded in achieving our reform proposals that year and in defeating the move by Golden Rule. We did so by exposing that threat and intimidation to public scrutiny. I shared with the Iowa General Assembly and my Governor the strategy and threats of Golden Rule. At that stage it became impossible for Golden Rule to win because those are not accepted strategies or methodologies in the State of Iowa and do violate the standards of conduct in lobbying.

Golden Rule across the country continues to oppose other insurance reforms and purchasing reforms. In Iowa, at least, I think their tactics have changed. Since that time they have retained local lobbyists and counsel in dealing with the Iowa Division of Insurance and have adhered to the standards of conduct in lobbying through information. I will note that we have seen, just as a follow up to previous comments, we have seen the Council for Affordable

Health Insurance operating in the State, but they have not been a major player.

Chairman Dingell asked upfront what was wrong with the current system and maybe for some lessons on what could be improved. Frankly, we have difficulty because of a fragmented risk pool. We have an inadequate basis of consumer information on which consumers can make informed decisions.

For the most part, the only thing that insurance consumers know is the price of the product they are buying and price has very little relation to either benefits within the policy or the quality of services delivered under the policy. Price for the most part reflects who the consumer is sharing risk with.

If members of that insurance pool are predominantly old and sick, the price is high. If members of that insurance pool are predominantly young and healthy, the price is low. They have very little information with regard to relative quality of various insurance plans or companies or on the value, that is the balance between price and quality.

Under insurance rules currently in place in most States, particularly in the individual market, there is a lack of ability to vote with consumers' feet; that is, there is lack of portability and continuity. Every time a consumer changes jobs or changes health plans, they are subject to a new round of underwriting or exclusion or waiting periods.

Also there is a lack of organized buyers to counterbalance the influence of organized sellers. The States are working on these issues. In portability and continuity, that is one of the major benefits of small group reform. In organizing small buyers to effectively negotiate with the sellers of insurance services, the Voluntary Health Insurance Purchasing Cooperative is being created at the State level and various congressional proposals do seek to address these concerns. What we lack is a single set of rules applicable to all players, all offerers of health plans regardless of size whether insured or self-insured, all marketers of health plans, and all sponsors of health plans.

Congress must distinguish between the best interest of the sellers, the best interest of individual buyers, and the best interest of buyers and consumers as a group or a society. Remember: You represent society. Government is responsible for the rules.

I cannot fault Golden Rule for seeking to profit under the current rules of the game. That is the current incentives. If you don't like the outcome of the current rules of the game, it is government's responsibility to set the rules.

I am concerned about the influence of special interests on reshaping the rules of the game. Government should be motivated to change the current rules. They are not working in the best interests of consumers. Congress should be very resistent to all special interests seeking new rules favorable to them, creating special advantage or private exemptions.

There are two major areas of reform in the voluntary market under consideration by Congress. The first area is in purchasing reform; that is, organizing the community of local buyers to effectively negotiate price and quality with a community of local sellers

of health plans in the form of voluntary health insurance purchasing cooperatives.

This is an important power to assist consumers in voting with their feet and in ensuring that there is accountability for value produced by health plans. There is also insurance reform and often we miss in talking about insurance reform that it is not just insurance companies that are engaged in the issuance of health plans. Insurance consumers use insurance very generically to refer to all sorts of health plans offered by self-funded employers and the Federal Government's Employee Retirement Income Security Act, health maintenance organizations and insurance companies. Congress needs to establish fair rules of the marketplace to assure better value, better quality at lower cost for all players.

Insurance reform is not free health care for all. It is not all that might be desired from health care reform. I have to tell you that voluntary reforms will not accomplish universal coverage. Guaranteed or mandated benefits cannot be financed with voluntary contributions. Substantial subsidies will be required.

There are minimum steps that we would ask Congress to take in 1994. We need a single set of rules for all players in insurance. Insurance reform must have a single set of standards to all who sell, administer or sponsor health plans whether insured or self-funded. Special exemptions should be avoided. Access should be the same standard for all health plans. All health plans, marketers and sponsors, must play under the rules of guaranteed issue with a limited waiting period for preexisting conditions if the consumer has not been contributing to a health plan, but otherwise providing for full portability and continuity of benefits between health plans.

Rating. All plans must play by the same standards of rating whether that is modified community rating or pure community rating, portability and continuity and fair administration and financial security. Consumers are counting on Congress to represent the public interest and to recognize and resist those seeking private advantage at the expense of the broader community.

In insurance reform, every special exemption that you grant somebody or preserve a discount currently enjoyed is an increase borne by somebody else in the system. All insurance does is average the cost that you ask it to average. There are tremendous opportunities for improvements in administrative costs and burdens and reductions so that money can be spent on health care rather than administration, but it is your responsibility to set the rules of the game and to resist special interests in their pursuit of special advantage or private interests.

Thank you.

[The prepared statement and attachments of Mr. Winegarden follow:]

United States Congress
Subcommittee on Oversight and Investigations of the
Committee on Energy and Commerce U.S. House of Representatives
The Honorable Rep. John D. Dingell, Michigan, Chairman
August 3, 1994
Testimony of:
Daniel Pitts Winegarden, First Deputy Insurance Commissioner
State of Iowa

Introduction.

The Honorable Chairman Dingell and members of the Oversight Subcommittee, thank you for the opportunity to testify today. My name is Daniel Pitts Winegarden, and I am First Deputy Insurance Commissioner for the State of Iowa. In addition to my duties as First Deputy, I have been the Governor's health care policy architect for the last two years. In both capacities I have listened to and spoken with thousands of Iowans concerned about the need for health care reform. I have also been in the center of drafting legislative proposals that serve the needs of all consumers. I was formerly counsel to the Commerce Committees of the Iowa General Assembly for four sessions. I work closely with members of both parties to craft workable reforms. In Des Moines as in Washington, D.C., some special interests have worked hard to assure that the new rules of health care delivery and financing are constructed to their advantage -- to make sure that reform means change for the other guy. As Congress is buffeted by the competing demands of special interests and tries to sort through to the common thread of the public interest, I have been asked to relate some of Iowa's experiences in the course of health care reform and to draw some lessons or recommendations to aid Congress.

In particular, given a panel scheduled later in the day, the Subcommittee requested a retelling of an early skirmish involving what I deemed to be inappropriate lobbying threats seeking special advantage at the expense of consumers. The incident involved Golden Rule Insurance Company, well known to state regulators and Congress for its aggressive pursuit of rules favorable to its financial success through lawsuits and lobbying.

Government is responsible for establishing fair rules that apply to everyone.

Iowa like many states began addressing the health care crises by trying to reshape the rules of access to and pricing of insurance. We sought to assure that consumers could keep their insurance when they needed it the most, when they got sick -- or in insurance jargon, developed preexisting conditions. Current insurance market rules too often encourage health plans to compete based upon risk avoidance -- insuring only the healthy.[1] Insurers avoid consumers with preexisting conditions or price the sick out of the market.

[1] Consumers use "insurance" generically to refer to private health plans, but not all health plans are insurance. State regulated insurance makes up less than half of the private health plan market. More than half of all Americans under age-65 are covered through employer self-funded health benefit plans authorized under the federal Employee Retirement Income Security Act (ERISA) of 1974. While many self-funded plans are administered by insurance companies, it is essential that ultimate reform address the entire market, both the traditional insurance market and the nontraditional self-funded market. Unequal standards will cause a continued shift of covered lives away from the more tightly regulated insurance market and to nontraditional venues with less protection.

Iowa's new paradigm seeks to force insurers to compete based upon risk management and better health care through prevention and effective early intervention. Broader risk acceptance and risk spreading is essential to this vision. Insurance plans must at least take all comers who have prior qualifying coverage to assure that people who have contributed to the pool while healthy are not carved out when they become sick.[2]

Iowa Reform Vision

Iowa is encouraging the development of teams of health care providers able to live within a customer defined budget and competing for patients based upon value, the best combination of cost and quality. Iowa was one of five states that drafted the original National Association of Insurance Commissioners (NAIC) small group reform act and was one of the first to fully implement small group reform. Iowa is encouraging the development of integrated health delivery networks serving both urban and rural Iowa. Iowa authorized a limited number of privately operated, publicly regulated health insurance purchasing alliances. Iowa now has a statewide purchasing cooperative in operation offering small businesses the buying clout of large employers, and offering the *employees* of participating employers choice between seven different types of plans from five different insurance carriers and health maintenance organizations.[3]

Iowa still needs Congressional Action on Health Care Reform.

All of this has been accomplished in close cooperation with Iowa's health care delivery community and insurance community. We have not resorted to demonizing current participants in the system. Iowa invested its time and effort in identifying problems and seeking mutually beneficial solutions. Iowa did not waste time on affixing blame. For the most part, doctors, hospitals, pharmaceutical companies, and insurance companies are simply trying the best they can to be successful under the current rules of the marketplace. If those rules are not producing socially desirable results, it is time to change the rules. It is government that is responsible for the rules. Because much of the market is beyond the jurisdiction of state law, Iowa needs Congress to get the rules of a reformed system right.[4]

---

[2] A corollary rule: marketing channels should not act as a filter to perpetuate risk avoidance. For instance, if rating by industry is banned in insurance reform, then association plans organized by industry cannot be separately rated but must be blended into the broader community pool. To give one industry a break necessarily increases the costs of another industry. Insurance just averages whatever the rules require insurance companies to average.

[3] Three key market reforms are offered by authorizing voluntary alliances as a sort of insurance buying club for small buyers. First, alliances concentrate buyers geographically. Health care is bought and sold locally. To copy the economies of scale and market clout of large employers, alliances must have market leverage in local markets. (This is one of several key distinctions between most existing association plans and voluntary alliances.) Second, alliances provide small buyers with a representative to negotiate on their behalf with the sellers of insurance and health care services. Big business can afford to have such experts in house. Small business and individuals need similar expertise to effectively exercise the market clout. Third, alliances offer employee choice of plan. This takes employers out of a position of conflict with employees and makes health care plans accountable to the ultimate consumers of health care for quality.

[4] Iowa is typical in that only about 25% of all health care dollars fall under state jurisdiction. Approximately half of all dollars flow through the two federal government health care entitlement programs of Medicare and Medicaid. Of the remaining half that is the private health benefits market, ERISA governs approximately one half, or a quarter of all health care dollars. State jurisdiction is limited to insurance companies and health maintenance organizations (when these entities assume insurance risk, but not when merely administering ERISA self-funded plans) and to local and state public employees. States have limited authority over Medicaid.

Single Set of Rules.

Many health reform advocates talk about a single-payer system. What we really need is a single set of rules. People doing essentially the same thing should be subject to the same rules. All buyers should play by the same rules -- including government as a buyer of health care services. And all sellers of health plans should play by the same rules. When offering health plans, the offeror must be subject to the same standards of access, rating and claims administration, whether organized as a insurance company, self-funded employer, whether the route of access is through an individual agent, direct marketing, an association, or a purchasing cooperative.

There is an area of danger where fault may attach to private players. It is not evil or wrong to strive to succeed under the current rules of the game. It is less innocent and more dangerous to manipulate the rules for private advantage at the expense of the community. Government must be careful not to allow special interests to overrule the general interest in setting the rules, creating special exemptions or private advantage. Flawed reform will ultimately fail.

The public interest can prevail. Let me illustrate with Iowa's experience with Golden Rule.

Regulatory Review of Rates for Fairness

Health insurance rate review statutes (including Iowa's) typically provide that rates must be filed with and approved by the Commissioner prior to use.[5] Health insurance rates are adjusted by using past experience to predict future losses. Iowa and other states believe that these rate adjustments or rerates are also subject to Commissioner review and prior approval. Iowa historically exercised this rerate authority. Then in 1991 an out-of-state insurance company, Golden Rule advanced a logically strained reading of then current statutory language to contest that the Iowa Commissioner did not have statutory authority to review rate adjustments or rerates. In essence Golden Rule argued that the Commissioner's original rate review could be made meaningless six months or a year later by a unilateral rate adjustment not subject to prior Commissioner approval. Iowa domestic insurance companies accepted Iowa's prevailing practice of prior rate review and approval because we do it promptly and fairly.[6]

---

[5] Iowa reviews individual and small group rates, but not large group rates. Large groups are presumed to be large and sophisticated enough to shop for a fair balance between cost and benefits. Individuals and small businesses require more proactive rate oversight on their behalf because they lack the expertise and negotiating clout to individually protect their interests. This lack of clout or need for an advocate in negotiating cost and quality with health plans is one reason why the concept of health insurance purchasing cooperatives or alliances are popular with small buyers -- individuals and small businesses. Through an insurance buying club the community of local buyers can organize to negotiate with the community of local sellers of health plans services. This alliance of buyers can capture the economies of scale, administrative expertise, and buying clout enjoyed by large buyers.

[6] In fairness, not all states approve rates within the strict time limits used by Iowa. Many states have backlogs of months in rate review and approval. Some without action even when rerates are reasonable. Iowa Insurance Division standard practice is to respond to a rate filing within 5-7 days. We hold ourselves to a strict standard with a statutory "deemer" provision that says, "a rate is deemed approved unless objected to" within a limited number of days. Iowa uses a staff actuary to assure company request rerates are fair and justified. Even recognizing that some company objections have merits in other states, Iowa is not a problem, and the lack of explicit rerate authority subjects the Iowa Commissioner to the prospect of costly litigation to reaffirm existing authority.

Minimum Guaranteed Loss Ratio Proposal

An alternative to prior rerate review and approval is advocated by some in the industry, including Golden Rule, an Illinois domestic insurance company with its principal place of business in Indianapolis, Indiana. The Iowa Division of Insurance opposed minimum guaranteed loss ratio legislation as advocated by Golden Rule and thus this story.

The issue was first raised in 1991 by Golden Rule during the legislative session. It proposed legislation that exempted it from regulatory review of rates so long as it maintained a loss ratio of 55% -- or more simply stated returned 55 cents on the premium dollar to consumers in benefits. Because it was such a major departure from current practice, the Division asked Golden Rule that it be deferred for study over the interim. We agreed to review the concept and consider it if the concerns of the Division could be adequately addressed and if consensus of the Iowa industry could be developed. This fairly established and agreed to minimum threshold was not met. While, the Iowa Life Association studied the concept, no consensus was reached between the Iowa domestic health insurers on the Golden Rule proposal.

The Iowa Division of Insurance's opposition to Golden Rule's position was not a knee jerk response. The company failed to comply with agreed to procedural standards and failed to demonstrate any common ground between their special interests and the public interest the Commissioner represents as the consumer's advocate.

Threats and Intimidation

As the Commissioner's First Deputy and legislative liaison I was responsible for preparing the Division's legislative package and working with legislators and lobbyists to advance the Commissioner's public policy initiatives. I did not receive any final work product from Golden Rule during the interim. The minimum agreed to threshold was not satisfied by Golden Rule. But on January 31, 1992, three weeks into the new legislative session, I received a call from Golden Rule's chief lobbyist threatening an all out fight if the Commissioner did not acquiesce to their demands. Steven Baer, the company's lobbyist, stated that Golden Rule was prepared to spend whatever was necessary on both advertising and lobbying to prevent the Iowa Insurance Commissioner from exercising continued rate review (rerate authority) and to obtain its favored standard of minimum guaranteed loss ratio. The lobbyist specifically mentioned $500,000 was available for the Iowa war chest. He reminded me of Golden Rule's history of suing Insurance Commissioners. He also said Iowa was a priority precisely because we had a good reputation in insurance regulation and was a trend setter. The intimidation was not subtle. The motive not well concealed. Convince Iowa, and other states would follow.

That is not what happened. The Division's 1992 proposed regulatory bill already included an express provision reconfirming the Commissioner's authority to review rerates. It endorsed rerate authority traditionally exercised and eliminated any chance of costly litigation. Neither I or the Commissioner acceded to Golden Rule's ultimatum. Instead we simply shared the above story with the Iowa General Assembly and Governor. For Golden Rule's announced strategy to work, Iowa's elected officials would have to admit that threats, one-sided advertising, and money have undue influence on public policy. Simply by making the threat public, and exposing it to the light of public scrutiny, it became impossible for Golden Rule to win this round.

The Division also succeeded by providing clear and convincing explanations of how Golden Rule's proposal was not in the best interest of Iowa consumers or Iowa companies. For additional background, that information is attached. But in essence, Golden Rule, a company with half of one percent of the Iowa market was seeking to dictate rules that permitted it to escape state oversight of rate fairness and that would "require" it to return to consumers two-thirds of the average amount returned by the industry on average. Golden Rule called this reform.

Golden Rule Opposes Other Insurance Reforms

Minimum guaranteed loss ratios were not the end of Golden Rule's efforts. Since then they have opposed small group reform and individual insurance market reform. Iowa implemented small group reform anyway, providing limits on rating practices and portability and continuity of coverage within the state regulated insurance market. Unfortunately, Iowa has not yet adopted individual insurance market reforms. This year the Iowa Division of Insurance advocated extending insurance reform to the individual market in a manner similar to that successfully implemented in small group. Our proposed legislation would guarantee access to a standard replacement policy at community average rates regardless of preexisting conditions. Special interest amendments bogged this significant reform down and it did not pass.

Insurance reform is not free, unlimited health care for all. It will not solve the crises for the uninsured. Only significant subsidies can place health insurance (whether public or private) within the reach of the bulk of the uninsured -- the young working poor. Insurance reform can and should make the market far fairer for those consumers who are insured. It can and will make the insurance market more stable and accountable. These are significant improvements over the status quo. They are not all that might be desired from health care reform. Insurance reform would solve the problem of consumers trapped in insurance premium death spirals. Insurance reform would assure consumers could get affordable replacement coverage when dropped from an employer's plan due to unemployment, early retirement or other causes. This seems the minimum that Congress should accomplish.

Conclusion

In considering health care reform legislation, I ask Congress to represent the broad public interest in insurance reform. Adopt a single set of reform standards applicable to all who sell or administer health plans. Do not grant special exemptions or exceptions or create special advantages. Allow consumers choice, including the choice of limited panel managed care plans, but assure that health plans, marketers, and sponsors all play by the same rules of access (e.g., guaranteed issue), rating (rates not based on health status), portability and continuity (no preexisting condition limitation or waiting period if the consumer had prior qualifying coverage, i.e., if the consumer has been making contributions to the community health care pool prior previously).[7]

[7] Congress must make a choice between voluntary and mandatory systems. Universal coverage that guarantees or mandates benefits cannot be achieved through voluntary financing. If financing is voluntary there must be some encouragement or penalty for people to buy health insurance. At minimum in a voluntary market a preexisting condition exclusion or waiting period is necessary if the person has no prior coverage. Once past the initial waiting period people should be free to move between health plans with no new preexisting condition

Attachments:

1. Memo to Governor Terry E. Branstad and Legislative Leadership, re: Regulatory review of health insurance rates and exposing Golden Rule's conduct.
2. Memo to Iowa State Senator Richard Varn, re: Guaranteed Minimum Loss Ratios, detailing the conflict with the public interest of Golden Rule's efforts in Iowa.
3. DRAFT memo, to Governor Terry E. Branstad and Legislative Leadership, re: Regulatory review of health insurance rates. This memo is a longer version of the final memo contained but is included because it includes additional information about Golden Rule and it was prepared contemporaneous with the events described.
4. "Fight over insurance review looms," *The Cedar Rapids Gazette*, Friday, March 6, 1992, describing Golden Rule's tactics and the Iowa Insurance Division's response, including an quotes from then Iowa Insurance Commissioner, David J. Lyons.
5. Memo to Ted Totman, Office of Senator Charles Grassley, re: Regulatory principles of voluntary Health Insurance Purchasing Cooperatives (HIPCS) or Alliances and notes on insurance reform.

---

limitation or waiting period. That is reform should provide for portability and continuity of benefits when changing health plans or changing employers, with no gap in coverage so long as there is no significant break in premium payments. A six to twelve month preexisting condition waiting period is appropriate.

TERRY E. BRANSTAD, GOVERNOR

INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

TO: Governor Terry E. Branstad
President of the Senate Michael E. Gronstal
Speaker of the House Robert C. Arnould
Senator Patrick Deluhery, Chair Senate Commerce Committee
Representative Steve Hansen, Chair House Commerce Committee
Members of the Iowa Legislature
FROM: Daniel Pitts Winegarden, First Deputy Insurance Commissioner
DATE: January 31, 1992
RE: Regulatory review of health insurance rates.

Commissioner Lyons' first rule is, "Do the right thing for the right reason." I need to share some background with you so that you understand the Division's position on an issue you may be called on to resolve, and to assure you I am following the first rule.

Health insurance rate review statutes (including Iowa's) typically provide that rates must be filed with and approved by the Commissioner prior to use. Health insurance rates are adjusted by using past experience to predict future losses. Iowa and other states believe that these rate adjustments or rerates are also subject to Commissioner review and approval. Iowa has historically exercised this rerate authority. Some companies take the position that the Commissioner's original review can be made meaningless six months or a year later by a unilateral rate adjustment not subject to prior Commissioner approval. Iowa domestic companies accept Iowa's current practice of prior rate review and approval because we do it promptly and fairly.[1]

An alternative to prior rerate review and approval has been advocated by some in the industry, including Golden Rule, an Illinois domestic insurance company with its principal place of business in Indianapolis, Indiana. **The Iowa Division of Insurance opposes minimum guaranteed loss ratio legislation as advocated by Golden Rule.** The issue was first raised last year by Golden Rule during session. Because it was such a major departure from current practice, the Division asked Golden Rule that it be deferred for study over the interim. We agreed to review the concept if the concerns of the Division could be adequately addressed and if consensus of the Iowa industry could be developed. **This fairly established and agreed to minimum threshold was not met.** While members of the Iowa Life Association studied the concept, no consensus of Iowa domestic health insurers was reached on the Golden Rule proposal.

I did not receive any work product from Golden Rule during the interim. But today I received a call from Golden Rule's chief lobbyist threatening an all out fight if the Commissioner did not acquiesce to their demands. Steven Baer, the company's lobbyist,

LUCAS BUILDING / DES MOINES, IOWA 50319 / 515-281-5705

stated that Golden Rule is prepared to spend whatever is necessary on both advertising and lobbying to prevent the Iowa Insurance Commissioner from exercising continuing rate review (rerate authority) and to obtain its favored standard of minimum guaranteed loss ratio. The figure of $500,000 was mentioned.

The Division's 1992 regulatory bill includes an express provision to review rerates. This reaffirms rerate authority traditionally exercised and eliminates any chance of costly litigation. Continuing rate review is a regulatory standard generally accepted by Iowa public officials.

Golden Rule has announced their intentions to block reaffirmation of the rerate authority and get their own substitute amendment for minimum guaranteed loss ratios.

I hope you can understand that Commissioner Lyons cannot accede to Golden Rule's ultimatum.

I ask for your support of the Commissioner's position, and assistance in the passage of the Division's insurance reform measures this year.[2]

d:\amipro\docs\GoldenR.sam
3.5disc5
dpw/2/1/1992

[1] In fairness, not all states approve rates within the strict time limits used by Iowa. Even companies that accept Iowa's rerate authority, object to the way some states exercise rerate authority, and thus object to explicit rerate authority on principle. Many state have backlogs of months in rate review and approval. Some withhold action even when rerates are reasonable. Iowa Insurance Division standard practice is to respond to a rate filing within 5-7 days. We hold ourselves to a strict standard with a statutory "deemer" provision that says, "a rate is deemed approved unless objected to" within a limited number of days. Iowa uses a staff actuary to assure that company requested rerates are fair and justified. Even recognizing that some company objections have merit in other states, Iowa is not a problem, and the lack of explicit rerate authority subjects the Iowa Commissioner to the prospect of costly litigation to reaffirm existing authority.

[2] Iowa domestic insurers provide coverage for well over half of the Iowa market. Iowa companies continue to work for consensus on an amendment to the mutually agreed upon rerate language contained in the Division's bill. The amendment would permit the use of mutually acceptable, objective rerate review standards. If work is completed on the amendment it will be offered this session.

TERRY E. BRANSTAD, GOVERNOR

INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

TO: Senator Richard Varn, Chair
Senate Standing Commerce Subcommittee on Insurance
FROM: Dan Winegarden, First Deputy
DATE: March 5, 1992
RE: Guaranteed Minimum Loss Ratios.

You asked for a summary of the technical arguments against guaranteed minimum loss ratios as proposed by Golden Rule. I am working off of last year's proposed bill by Golden Rule. The company has, as previously noted, absolutely failed on its commitment to develop a proposal for review by the Insurance Division over the interim. I do not know what they may offer. This is a compilation of comments received from:

1. Bob Howe, Deputy Commissioner and Chief Examiner, President of the Society of Financial Examiners and a nationally respected expert on insurer financial oversight.
2. Roger Strauss, Bureau Chief of Life and Health, whose bureau is primarily responsible for the review of rates and forms for compliance with Iowa law.
3. Klete Geren, the Division's Life and Health actuary, responsible for rate analysis.

Golden Rule's proposal has received extensive review and is unanimously opposed by the Division's experts and Iowa industry. Some of the reasons include:

- ☐ **Rerate review and approval is working for Iowa consumers and companies.** Iowa has an adequate, but not excessive rate structure that continues to work well. Iowa domestics represent over half of the insured market and support the Division's rerate authority. Recomfirmation of rerate authority assures we do not waste scarce state funds on an unnecessary lawsuit to confirm accepted public policy.
- ☐ **Rate review is for three reasons, not just to prevent excessive rates.** The Division reviews rates on three basis:
  - **Rates cannot be inadequate.** (Protect the solvency of the company.)
  - **Rates cannot be excessive.** (Rates must be reasonable in proportion to the benefits provided.)
  - **Rates cannot be unfairly discriminatory.** (Underwriting decisions must be supported by actuarially sound – statistically valid – data. Arbitrary and capricious rate setting by companies is not desirable.)
- ☐ **Not the national standard – Accreditation concerns.** Golden Rule's proposal does not fully address the State's legitimate interest in reviewing rates on all three grounds. Minimum guaranteed loss ratios as advocated by Golden Rule are not

LUCAS BUILDING / DES MOINES, IOWA 50319 / 515-281-5705

supported by the National Association of Insurance Commissioners. There may be concerns regarding Iowa's hard won accreditation by the NAIC or attendant insurer solvency issues if such mechanisms were adopted. This is a critical question Golden Rule failed to answer by not following the agreed upon procedure. Golden Rule implies there is an NAIC model on this topic. Untrue. The American Academy of Actuaries has a model submitted to the NAIC, which was not accepted as a model. Further, the NAIC is developing a comprehensive rate review model that may include objective standards, but is far different than the minimum loss guarantee proposal advocated by Golden Rule. **Real danger of Iowa being out of the regulatory mainstream if we accept Golden Rule's proposal.**

- ☐ **Answers a problem Iowa does not have.** Guaranteed minimum loss ratios are essentially a pre-approval mechanism for future rate increase which relieves the company of any continuing rate oversight by the Commissioner of Insurance. Given the rapid pace of health care cost inflation, it may make sense in states where companies do not receive timely review of rate increase requests or rates are politicized. That is not the case in Iowa. The Division gives prompt turnaround time on both form and rate requests. There is no need for this automatic mechanism to avoid delays as turnaround time is never longer than 10 days, and in most cases is 5 days or less. **Currently, the Division's use of an on-staff actuary assures uniformity of analysis and treatment between companies.**

- ☐ **Ability to game the system.** These rules were drafted by a company with a purpose. Not all of the nuances may be fully disclosed. In any case, the Division's experts are very concerned about the ability to manipulate reserves and other methods to game the system so that the loss ratio is achieved or exceeded and thus refunds are never made or are minimal. A good question to ask the company is how much has been refunded to consumers to date (both in total dollars and as a percentage of premiums collected).

- ☐ **Potential to low-ball premiums to buy market share.** The proposal does not prevent low-balling of the premium knowing that the guarantee and loss ratio concept will automatically bring the premiums up to offset the initial low-ball premium. This is a special concern in health care were increasing age or change in health status may prevent a person from exercising real choice to change insurers once committed. The threat of being denied coverage for pre-existing conditions exist whenever consumers switch sources of coverage. This is one reason the Division's proposed reforms in the small group market are targeted at continuity and portability of benefits.

- ☐ **Low loss ratio.** Golden Rule proposes that only 55% of premium dollars be returned to consumers in benefits. In comparison, the current market average loss ratio is 79.89% for the top 109 health insurance companies representing 97% of the

market. 67% when the top writer, Blue Cross/Blue Shield is taken out. 74% for only Iowa domestic carriers.

- **Dependence upon independent auditors and private actuarial opinions.** As enforcement mechanisms, standing alone, the Division does not have whole-hearted confidence in either independent auditors or private actuarial opinions. Regulatory oversight of both the reviewed entity and the audit or opinion letter are necessary to assure compliance. Savings & Loans go insolvent on a regular basis with independent audits attesting to their financial strength.

  The range of reasonable actuarial opinion can be equally wide. One reason the Division retains actuaries on staff is to assure consistency of analysis between rate filing reviews, and thus equality of treatment between companies. Golden Rule's proposal assures that similarly situated companies will have different results. Golden Rule would provide the greatest advantage to the company best able to buy a favorable private opinion. It encourages gamesmanship and abuse rather than fair and conservative behavior.

- **Who gets the refund?** If a refund is required, to whom would it be paid? How does the company locate the policyholder, especially since some people have died, some have moved, and some have lapsed their policies. A better question yet, how does the Division assure payment is made? The whole point of the proposal seems to be to escape regulatory oversight. What happens to the money which cannot be refunded, for whatever cause? (If Golden Rule had worked with the Division as they promised, I would be able to answer these questions.)

- **Iowans will be forced to share the loss experience of other more expensive states.** The Golden Rule proposal has a $1 million threshold. Blocks smaller than $1 million are allowed to share risk across state lines.

  According to the Commissioner's 1991 report to the Governor covering the policy year 1990, there were only 4 domestic companies that had premium volumes in excess of $1,000,000 for ALL individual accident and health business (much less a single block of business). (Principal, Farm Bureau Life, National Travelers, and American Republic.) There were 30 non-domestic companies that had Iowa volume in excess of $1M. Each of these companies has multiple forms. It is doubtful whether any one policy form or block of business would ever reach $1 million in Iowa premium by itself. Therefore, according to Golden Rule's proposal, the rate increase, the refunds or payments would result from experience pooled across several states. The Division's actuary notes that it will be impossible to assure Iowans do not subsidize higher losses in other states. This is a very likely outcome given Iowa's relatively favorable health care costs. The loss ratio experienced by Iowans will actually be less than that promised.

- **Inconsistent with rule that Iowa rates shall be based upon Iowa experience.** Iowa has successfully enforced a policy that Iowa rates must be based upon Iowa loss experience to assure that Iowans get the benefit of cost containment, favorable cost and utilization patterns and tort reform. Why should Florida consumers get the benefits of Iowa's relatively low health care costs, in part attributable to tort reforms limiting medical malpractice exposure? (Medical malpractice rates were reduced 40% on average within the last two years in response to Iowa tort reforms and a market review by the Iowa Division to assure that reforms were reflected in rates.)

  Iowa has in fact taken a strong stance on California's Proposition 103 to assure that refunds to California consumers do not come from surplus or reserves attributable to Iowa consumers. Given this consistent policy, Iowa should not support a system that permits multi-state losses to impact the rates Iowans pay. Right now we control our own destiny. Golden Rule wants to take our rudder away.

- **Golden Rule has half-one percent of the Iowa accident and health insurance market.**

- **Iowa domestic insurers do not support the Golden Rule Proposal.** Iowa domestic companies represent over half of the Iowa market oppose Golden Rule's proposal.

- **Threatens the cooperative partnership that has produced nationally low insurance rates and high insurance business growth.** Approval of the Golden Rule proposal would fly in the face of the cooperative, consensus based approach that has been the distinguishing feature of Iowa's insurance regulatory and business climate.

The Division is working with the Iowa industry on reducing to paper objective rate review criteria, a process that might produce something similar in some aspects to guaranteed minimum loss ratios. That is an on-going project and will continue after the requested legislative re-confirmation of re-rate authority. For now, consistency of treatment is assured of companies seeking rerate approval due to the actuarial talent the General Assembly funded in recent years for the Division. There are a bundle of outstanding questions we had intended to ask Golden Rule in the course of the agreed to interim project. We never got that opportunity. **The Division simply has not reached any level of comfort to acquiesce to a major change in the form of rate regulation with unknown consequences for Iowa consumers.**

A good old rule of thumb applies, **"If it ain't broke, don't fix it."** The Division asks that rerate authority be expressly stated to avoid unnecessary litigation and that Golden Rule's minimum guaranteed loss ratio be rejected.

TERRY E. BRANSTAD, GOVERNOR

Governor Mule

[404]

FOR DISCUSSION PURPOSES ONLY

INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

Dan - looks good 2 small change on 8 3 Terry

TO: Governor Terry E. Branstad
President of the Senate Michael E. Gronstal
Speaker of the House Robert C. Arnould
Members of the Iowa Legislature
FROM: Daniel Pitts Winegarden, First Deputy Insurance Commissioner
DATE: January 31, 1992
RE: Regulatory review of health insurance rates.

As you know, Iowa has developed a reputation for strict, but fair regulation of the insurance industry by establishing a partnership between consumers and companies. Companies that treat consumers fairly deserve a fair opportunity to make a reasonable profit. The result has been nationally low rates for insurance products and record growth for insurance companies. Iowa recognizes that consumers are not helped in the long-run by unprofitable companies. Low cost insurance is no bargain if the company is not there to pay on its promises. Rather than engaging in the political rate setting practiced by some states, Iowa has diligently implemented some basic regulatory philosophies:

☐ **Our priorities are:**

- **Solvency first.** Iowa is one of only 9 nationally accredited states for solvency oversight, soon to become a precondition for domestic insurers to engage in interstate commerce.
- **Consumer protection second.** Iowa has a national reputation for consumer protection and advocacy of progressive reforms. Iowa is notable for the range of choices offered consumers fostered by healthy competition. This competition has produced nationally low rates.
- **Insurance economic development third.** Iowa's insurance industry is growing at the fastest rate of any state in the nation.

☐ **Market oriented regulation is more effective than price oriented regulation.**

- A competitive market in which consumers have a reasonable range of choices to shop for both service and price will deliver the best rates and service.
- This allows us to focus scarce regulatory resources on sectors of the insurance market which are not competitive, and thus require greater oversight to assure fairness to consumers.
- Our goal is to induce market incentives to benefit the Iowa consumer, but not all areas are competitive.

☐ **Rates are preapproved in noncompetitive markets based on 3 tests:**

- **Rates cannot be inadequate.** (Protect the solvency of the company.)
- **Rates cannot be excessive.** (Rates must be reasonable in proportion to the benefits provided.)
- **Rates cannot be unfairly discriminatory.** (Underwriting decisions must be supported by actuarially sound -- statistically valid -- data. Arbitrary and capricious rate setting is no more desirable in companies than it is in the regulatory practices of some other states.)

- ☐ **Iowa rates shall be based upon Iowa experience to the greatest extent possible.**
  - We will not require Iowans to subsidize the losses in other states.
  - We will assure that the benefits of Iowa reforms accrue to Iowa rate-payers.

- ☐ **First class service to consumers and companies:**
  - The Division responds to over 37,000 consumer inquiries and complaints each year. Of course not every complaint is resolved in the consumer's favor, but in each of the last 4 years the Division has set records in:
    - the number of successful prosecutions of companies and agents,
    - the amount of money successfully recovered for consumers and fines collected.
  - The Division has zero backlog in responding to companies':
    - Form filings for review and approval.
    - Rate filings for review and approval.
    - Applications for admission to do business.
  - The Division's policy is to respond to company correspondence within 5-7 days of receipt.
    - This is in marked contrast to many states where response times are measured in months.
    - Of course the answer is not always, "Yes." It shouldn't be.
    - When the answer is, "No," the Division provides clear guidance on what the deficiency is and what remedy is expected prior to approval.
    - We hold ourselves to high standards by providing a "deemer clause." Rates are deemed approved if not accepted or rejected within a limited timeframe.

I am reminding you of Iowa's approach to insurance regulation and its successes because you **are all responsible.** Unique in the country, the Iowa Governor and Legislature over several years have worked cooperatively to implement these philosophies. **Together you have:**

- ☐ **Provided needed statutory authority for Division of Insurance to become accredited and otherwise provided the Commissioner with adequate authority to carry out the responsibilities charged to this office.**

- ☐ **Provided funding for key resources such as:**
  - **Computers** to facilitate field examinations, evaluation of investments, and rates.
  - **Actuaries** to review rate filings. The Division now has the same degree of professional expertise to review rates as companies employ in asking for rates Rate reductions ordered by our two actuaries have saved Iowa consumers over $40 million in each of the last two years. Division actuaries also assure uniformity of analysis between companies. If the Division were forced to rely upon private actuaries, we have discovered the range of reasonable actuarial opinion can be quite broad.

- ☐ **Facilitated insurance economic development that has created over 4,000 new jobs since 1988, by developing an unmatched infrastructure to support the business of insurance.**

Really, all of these principles can be reduced to one basic Iowa philosophy. Commissioner Lyons' first rule is, **"Do the right thing for the right reason."**

Unfortunately, not everyone lives by the same philosophy. I write to you today because this **balance is threatened** today. Not by you, but by an insurance company. Not an Iowa insurance company, or even a significant part of the Iowa market, but a company that wants to re-write the rules in its own favor, at the expense of Iowa consumers, Iowa companies and the Iowa insurance market. **You can help stop this.**

The company is Golden Rule Insurance Company of Columbus Ohio. Golden Rule campaigned last year for an automatic rate setting device called minimum guaranteed loss ratio. The concept as championed by **Golden Rule would remove all power of the Commissioner of Insurance to review health insurance rates** for the protection of either solvency or consumers. It is a classic example of for every problem there is a simple, and wrong solution. Worse yet, this idea is a solution to a problem Iowa does not even have -- long delays in rate review and approval. But Golden Rule wants Iowa to follow its lead to establish precedent for other states. Golden Rule wants to borrow Iowa's hard earned reputation for insurance excellence for its own purposes.

The Iowa Division of Insurance opposes minimum guaranteed loss ratio legislation as advocated by Golden Rule. Our concerns are detailed in a separate memorandum prepared by the Division's actuarial staff and health insurance specialists. The issue was raised last year by Golden Rule during session. Because it was such a major departure from current practice, the Division asked Golden Rule that it be deferred for study over the interim. We agreed to review the concept if the concerns of the Division could be adequately addressed and if consensus of the Iowa industry could be developed. This minimum threshold was not met by Golden Rule. While members of the Iowa Life Association studied the concept, no consensus of Iowa domestic health insurers was reached. (Iowa domestic insurers provide coverage for well over half of the conventional market. Golden Rule has a miniscule portion of the Iowa market.)

I did not hear from Golden Rule once during the interim. But today I received a call from Golden Rule's chief lobbyist threatening an all out fight if we did not acquiesce to their demands. Steven Baher, the company's lobbyist, stated that **Golden Rule is prepared to spend whatever is necessary on both advertising and lobbying to prevent the Iowa Insurance Commissioner from exercising continuing rate review** (rerate authority) and to obtain its favored standard of minimum guaranteed loss ratio. The figure of $500,000 was mentioned.

Golden Rule has sued other state insurance commissioners to prevent rate reviews. Rate review statutes typically provide that rates must be filed with and approved by the Commissioner prior to use. Health insurance rates are adjusted by using past experience to predict future losses. Iowa and other states believe that these rate adjustments or rerates are also subject to Commissioner review and approval. Experience and loss reserve data can be gamed both to endanger solvency and at the expense of consumers. Golden Rule takes the nonsensical position that the Commissioner's original review can be made meaningless six months or a year later by a unilateral rate adjustment subject to no legal standard or Commissioner oversight.

Unfortunately, Golden Rule beat commissioners in other states. Now they want to try Iowa.

The Division's 1992 regulatory bill contains includes **an express provision to review rerates.** This reaffirms rerate authority traditionally exercised and eliminates any chance of litigation. Continuing rate review is a regulatory standard generally accepted by Iowa public officials.

Golden Rule will try to block it and get their own amendment for minimum guaranteed loss ratios.

Golden Rule also objects to the health insurance reforms for the small group market recently adopted by the Iowa General Assembly in 1991 House File 688. Golden Rule promised to fight the follow-on National Association of Insurance Commissioner's model act on Guaranteed Access and Portability of Benefits as sponsored this year by Governor Branstad in Iowa and as contained in Senator Lloyd Bentson's health insurance reform Act in Congress. The step back towards community rating by inclusion is a nonpartisan consensus fix for the worst practices of the health insurance industry. **Golden Rule is a prime example of the predatory rate setting practices and exclusionary underwriting practices we have sought to remedy in Iowa through these reforms.**

Perhaps the best strategy would be to let them spend their money in Iowa. Put some Iowan's to work and then send them packing.

I ask your help in resisting temptation. The siren song sung by Golden Rule is compelling. Minimum guaranteed loss ratios are sold as a cure all for health insurance. They are not. Maybe it would make Golden Rule more profitable and competitive in Iowa, but it wouldn't help Iowa consumers or Iowa companies in Iowa. Our mutual successes are too precious to squander.

Remember, if it sounds too good to be true, it probably is.

b:\GoldenR_sam
3.5disc5
dpw/2/1/1992

FYI Dave X Den X

MONEY/AGRIBUSINESS

DJIA/3,241.50 27.0

BRIEFS

Boatmen's plans bank merger

■ Boatmen's Bancshares of St. Louis on Thursday announced plans to acquire Sunwest Financial Services Inc., an Albuquerque, N.M., bank holding company, for $337 million. Boatmen's, which plans to merge with First Interstate of Iowa next month, said Sunwest — with $3.4 billion in assets — holds the leading market share in New Mexico. Under the terms of the merger agreement, Boatmen's will issue 0.7722 shares of its common stock for each of Sunwest's 9.8 million shares of outstanding common stock. Boatmen's, with $18 million in assets, also has announced plans to buy an Arkansas bank holding company.

Czechs pull import request

■ DES MOINES (AP) — Rep. Dave Nagle said Thursday that the Czechoslovakian government had withdrawn a duty-free import request that would have meant competition for a Charles City drug company. Nagle, an Iowa Democrat, said Czech Ambassador Rita Klimova withdrew the request Thursday. Nagle previously claimed the competition would be "grossly unfair" because the Czech company paid low wages to its workers and did not have to worry about pollution laws that restricted domestic companies. Chemofarma had asked to export to the United States the drug sulfasalazine, used to treat severe dehydration caused by ulcerative colitis. The only domestic company making sulfasalazine is Salsbury Chemical, a Charles City firm that employs 120.

Magna sales, profits up

■ Magna International Inc. of Ontario posted sales and net income for the second quarter and first six months of fiscal 1992. The company, which operates five

Fight over insurance review looms

Iowa Newspaper Association

DES MOINES — A state official has accused a lobbyist for an Illinois-based insurance company of threatening "an all-out fight" if Iowa Insurance Commissioner David Lyons failed to implement a new procedure for establishing health insurance rates.

A memo by Daniel Winegarden, deputy insurance commissioner, said a lobbyist for the Golden Rule Insurance Co. was prepared to spend "whatever is necessary" on both advertising and lobbying to obtain its favored standard of minimum guaranteed loss.

Winegarden said the lobbyist, who was not named, mentioned the figure of $500,000 in a telephone conversation with him.

"Minimum guaranteed loss ratio is used by three or four states in setting health insurance rates," Lyons said. Some companies are pushing for the concept on a national level, he said.

Under the system, an insurance company guarantees a loss ratio of a certain percentage on its policies. If the loss ratio is less than the guarantee, the insured receives a refund of the difference.

"This means their policies are not subject to any rate review for adequacy, excessiveness or discrimination in that state," Lyons said.

The guaranteed loss ratio proposal is a response to insurance departments that are slow in setting insurance rates, according to Lyons.

"Most of the guaranteed loss ratio concepts we've seen so far are probably a bad idea for Iowa for several reasons," Lyons said.

"First, the guaranteed loss ratio percentages are normally set fairly low," he said. "For example, most of the companies that are pushing this on a national level want a guaranteed loss ratio of 55 percent on their policies.

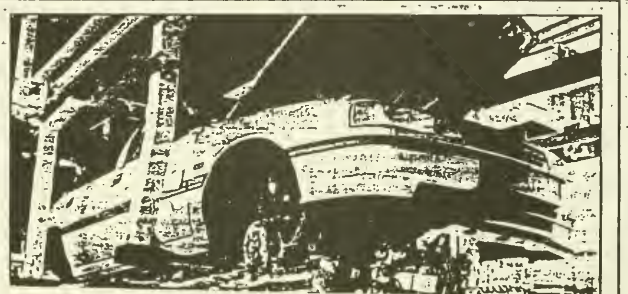
"This means they are required to meet the minimum ratio, paying 55 cents on the dollar of every policy. The existing loss ratio for a majority of Iowa companies is significantly higher, meaning they pay more to the insurance consumer than 55 percent on their claims.

"Secondly, we don't have the problem in Iowa that prompted other states to consider this," he said. "In Iowa, we have the shortest turnaround time on rates and forms for approval in the country, which is five days."

In Iowa, as in most states, health insurance rates are filed and are approved by the commissioner before they go into effect. Health insurance rates are adjusted by using past experience to predict future losses.

Iowa and other states believe that these rate adjustments are also subject to commissioner review and approval, Lyons said.

In proposed legislation, Lyons is asking lawmakers to reaffirm his adjustment authority. Tuesday, the Senate commerce committee approved a study bill that would reaffirm the commissioner's rate review authority.



Retailers post higher sales in February

By Joyce M. Rosenberg
Associated Press

The prolonged consumer spending slump showed further signs of ending Thursday as the nation's largest storeowners reported sales strengthened in February for the second straight month.

Retailers in all segments of the industry reported gains, and even expensive merchandise such as furniture and major appliances sold well. Some storeowners said sales were better than expected,

TERRY E. BRANSTAD, GOVERNOR

INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

TO: Ted Totman, Office of Senator Charles Grassley, Iowa
FROM: Dan Winegarden, First Deputy Insurance Commissioner
DATE: July 26, 1994
RE: Principled foundation for HIPC/Alliance enabling statute or rules.

We discussed briefly some principles of health insurance purchasing cooperatives or voluntary alliances this morning. Here is a brief summary of principles to be followed in enabling statutes or rules. These principles are important to tell the difference between enshrining the status quo and enabling voluntary reform. Health Insurance Purchasing Cooperatives (HIPCs) or Alliances are purchasing reform, not insurance reform. Especially in a voluntary market, insurance reform must be equally applied to *all* parties performing essentially the same function whether insurance companies, health maintenance organizations, ERISA-qualified employer self-funded plans, or others. Alliances are intended to discipline the sellers of health plans to deliver better value for the dollar, the best combination of cost and quality. The principles in no special order:

1. **Non-risk bearing.** HIPCs are intended to effectively organize the community of buyers to effectively negotiate cost and quality with sellers of health plans. The health plans bear risk, not the HIPC. No insurance reserves are necessary or appropriate because HIPCs do not engage in the business of insurance (acceptance of risk transfer). (I understand Ohio's law requires minimum insurance reserves at the lobbying pressure of Golden Rule Insurance. This reflects a fundamental misunderstanding of a HIPC's function. A HIPC is not a health plan or insurer.) HIPCs do require oversight of their fiduciary responsibility in handling money to the extent that payments are made through the HIPC.

2. **Organized for the primary benefit of purchasers, especially small buyers – individuals and small businesses.** Several conclusions flow from this principle. HIPCs cannot be controlled by those whose services are being purchased, insurance companies or health care providers. Small buyers need assistance to organize. There is no special reason to exclude large employers from participating. In fact the trend towards community level organization of buyers favors *not* restricting voluntary HIPCs to some arbitrary limit on the size of employers that may participate. This runs contrary to many bills in Congress where size limits are left over from when some were considering mandatory alliances. Insurance companies would be very happy to keep buyers small, diffuse, and unorganized. Size limits on voluntary HIPCs/alliances tend to make them weak and ineffectual, minimizing the benefits or reforms that could be realized from organized value-based purchasing. Rules should encourage aggregate purchasing power. Rules that fragment, divide or limit the size of a HIPC operate to the benefit of sellers of services, not buyers. Recognize that sellers are already far more organized.

LUCAS BUILDING / DES MOINES, IOWA 50319 / 515-281-5705

3. **Insurance industry and health care providers should not control structure of the alliance.** This has two corollaries. First, in structuring the rules for HIPCs, politicians should listen to *buyers* not sellers. Large sellers do not like organized buyers and will work to make HIPCs ineffectual and weak. Second, the internal governance of a HIPC should not be dominated by sellers. Don't permit insurance companies or health care providers to sit on both sides of the table.[1] Conflict of interest standards are appropriate.

4. **Service territories should follow de facto regional health care markets and not political borders.** The primary innovation of managed competition is the recognition that health care is bought and sold in local markets. HIPCs seek to organize the community of local buyers to effectively negotiate cost and quality with the community of local providers of insurance and health care services. Local health care markets cross geopolitical borders and overlap on the fringes. The regulatory structure should not Balkanize health care buyers with arbitrary hard boundaries, but should rather follow the boundaries of consumer-defined markets. Regulators do have an interest in assuring all areas are served by at least one HIPC and that HIPCs not be allowed to only serve high volume, low cost areas.

5. **Insurance reform initiatives should be applied equally inside and outside of the alliances.** Assuming that alliances will be a voluntary alternative and not the exclusive route to the insurance market, all routes must play under the same insurance reform rules. For instance, an alliance should not be required to take all comers (guarantee issue) if insurance companies marketing directly, and self-funded employers under ERISA are not similarly required to do so.

6. **A HIPC must offer more than one health plan and the products of more than one carrier.** A HIPC is more than a distribution channel for a single carrier or single product. This is a major distinction from association plans. A HIPC is intended to organize competition between competing carriers by facilitating choice between plans based upon cost and quality, or value.

7. **Price makers, not price takers -- the power to negotiate.** HIPCs must be value-based purchasers with the ability to apply the tools of continuous quality improvement to negotiate both cost and quality with potential participating health plans. Assuming that alliances will be voluntary and non-exclusive channels to the reformed insurance market there is no legitimate public interest served in requiring the alliance to list "any willing insurer". (A different conclusion is possible if alliances are mandatory and exclusive, but that does not seem to be the direction of either state or federal policymakers.)

---

[1] The issue of agents is a little more touchy. An independent agent not tied to a particular insurance company is more likely to represent the interest of client buyers than a tied agent selling directly for a particular company. Iowa has an independent insurance agent led alliance up and running. I would hope it would it at least enjoy a grandfather clause. It could be a model. If policymakers choose "voluntary" alliances, policymakers have to realistically assess who has the capacity and motivation to create voluntary alliances and effectively represent small buyers. Independent agents, large employer coalitions, existing associations willing to change from a single product to facilitating choice of competing plans, chambers of commerce, and state government are all possible sponsors able to organize and assist small buyers.

8. **Employee choice of plan.** HIPCs should offer employee choice of plans rather than employer choice of plans. Employers' legitimate interests in controlling costs are served by allowing the HIPC to negotiate prices with health plans. It is important to counterbalance this by giving individual employees choice of plan as a quality control check. A health plan subject only to employer influence over price may ignore quality. To succeed with employee choice of plan, the health plan must offer the best value -- the best combination of cost and quality.

9. **Exempt from antitrust.** Purchasers participating in an alliance must not be subject to antitrust violations by virtue of aggregating purchasing power. State regulatory oversight of the alliance on a continuing basis should provide the state action doctrine exemption from federal antitrust rules, but more explicit permission in federal law is desirable. Direct federal regulation or licensing of HIPCs would be preferable to having any problems with federal antitrust. Need to be able to clearly tell alliance organizers what is permissible up front. Buyers want to organize to save money on health care not spend money on lawyers.

10. **Voluntary HIPCs should be subject to less prescriptive rules than mandatory HIPCs.** Many issues should be left to the business judgment of the operators since they will be in competition with other distribution channels and potentially in competition with other HIPCs. There is no one right way to do a HIPC as local circumstances and priorities vary considerably. Avoid freezing current practices in regulatory stone as everyone is early on the learning curve. Value-based purchasing lessons from large employer coalitions and the few existing health insurance purchasing cooperatives are instructive.

Two other warning signs. It is my understanding that HIAA and others have circulated a regulatory template on Capitol Hill that includes in the fine print some provisions that endanger the viability and success of voluntary purchasing cooperatives.

The insurance community's proposal retains underwriting or eligibility determination as a function of the individual insurance company and not the HIPC. This is contrary to current practices of operating HIPCs in Iowa, California, Florida and Texas where the HIPC applies uniform eligibility tests to all consumers and the insurer must take anyone passing the HIPC's review.[2] The HIPC can assure uniform application of the standard. If ten different insurance companies apply the same standard there will by definition be ten different standards. To surrender the HIPC's power to apply uniform standards leaves insurers in a position to continue to manipulate the risk pool through risk avoidance. Because the HIPC does not bear risk it does not have the same incentive to avoid risk. Eligibility determination, where there is a HIPC or voluntary alliance, more appropriately rests with the alliance. With uniform eligibility determination through the HIPC and employee choice of plan, a real benefit is that risk tends to be more randomly distributed because insurers lose the powers necessary to directly perform risk avoidance.

---

[2] Underwriting or determining eligibility for enrollment will continue to be a function in a voluntary market. It appears to be the politically likely result that reform will at least initially feature voluntary alliances and insurance reforms, it looks like there will be a preexisting condition waiting period for those without prior qualifying coverage.

Similarly, insurers oppose allowing HIPCs to hold the group insurance certificate on behalf of participating employers and would like to maintain a direct insurance contract relationship with the employer. This of course would make it far easier to again choose to sell directly to low risk employers, by-passing the alliance, or to otherwise undermine the effectiveness of an alliance in aggregating the purchasing power of many buyers. All current alliances hold the group certificate.

In both matters, follow corollary 1 of rule 3, listen to buyers not sellers in setting the rules on how HIPCs/alliances should operate. All current successfully operating voluntary alliances perform uniform underwriting for all participating health plans and do not let participating insurers pick and choose consumers from among the HIPC's members. All current successfully operating voluntary alliances hold the group contract from the carrier on behalf of participating employers and their employees. The insurer must deal with the HIPC, not the employer. To follow the insurer's preferred model leaves the employer potentially dealing with multiple insurance companies, unless Congress also accepts employer choice of plan.

Alliances offer three tremendous changes over the status quo:

- ❑ Negotiated, market-based accountability for both cost *and* quality, i.e., value-based purchasing.
- ❑ Employee choice of plan to assure quality and consumer satisfaction. A recent survey showed that 80% of employers only offer one health plan. The unreformed employer choice of plan insurance market limits portability of coverage with preexisting condition limitations and waiting period and emphasizes cost avoidance not value.
- ❑ Streamlined administration by having the HIPC perform premium collection and underwriting. If done right, the HIPC does administrative tasks currently done by many insurance companies, eliminating current duplications and capturing economies of scale. If crippled by pro-insurance company requirements, alliances do become an ineffectual added layer of bureaucracy rather than an effective, more efficient substitute for current administrative practices.

Hope this helps.

Dan in w Weingarten

TERRY E. BRANSTAD, GOVERNOR

INSURANCE DIVISION
IOWA DEPARTMENT OF COMMERCE

United States Congress
Subcommittee on Oversight and Investigations of the
Committee on Energy and Commerce U.S. House of Representatives
The Honorable Rep. John D. Dingell, Michigan, Chairman
August 3, 1994
Briefing Points for:
Daniel Pitts Winegarden, First Deputy Insurance Commissioner
State of Iowa

- **Iowa's Golden Rule Story --**
  - Agreed to procedure for resolution of conflict not followed.
  - Threats and intimidation. $500,000 war chest for lobbying and advertising. Reminder of past law suits.
  - Pursuit of special advantage contrary to best interests of Iowa consumers and Iowa companies.
  - Exposure of threats to public scrutiny.
  - Public interest prevailed.
  - Golden Rule continues to oppose other insurance reforms and purchasing reforms.
- **Single set of insurance reform rules applicable to all who offer, market or sponsor private health benefit plans.**
  - General application of lessons Iowa learned in dealing with Golden Rule.
  - Government is responsible to establish fair rules.
  - Caution against granting special exemptions or private advantage at the expense of the general interest. — For instance if you desire community rating, every exception you grant to give someone a good deal increases someone else's insurance bill by the same amount. You know who gets the break. But you [illegible] [illegible].
  - Flawed reform will fail.
- **Two major areas of reform in a voluntary market under consideration.**
  - **Purchasing reform** -- organizing the community of local buyers to effectively negotiate price and quality with the community of local sellers of health plans through voluntary purchasing alliances. (Consistent with maintaining rating territories so that when health plans deliver better results for lower costs they can pass the savings onto their customers. Without geographic rating, there is no incentive to improve value.) Alliances are not health plans but a buying club to facilitate the purchase of health plans. Risk is borne and managed by the health plans.
  - **Insurance reform** -- changing the rules of health care financing to more broadly spread health care costs, to motivate risk management rather than risk avoidance, and

LUCAS BUILDING / DES MOINES, IOWA 50319 / 515-281-5705

to make health plans accountable in the marketplace for value, better quality at lower cost.

- **Voluntary alliances are not insurance reform.** They are purchasing reform and a complement to insurance reform. To be successful alliances must operate in a reformed insurance market.

❑ **Principles of voluntary alliance regulation.**

This bullet point and subpoints likely to be cut due to time constraints. With ten minutes, unlikely to get to these points.

- Non-risk bearing.
- Organized for primary benefit of purchasers, especially small buyers -- individuals and small businesses.
- Insurance industry and health care providers should not control alliance.
- Service territories should at minimum follow regional health care markets and not political borders.
- Insurance reform initiatives should be applied equally inside and outside of the alliances.
- An alliance must offer more than one health plan and the products of more than one carrier.
- Price makers, not price takers -- the power to negotiate.
- Employee choice of plan.
- Voluntary alliances should be subject to less prescriptive rules than mandatory alliances.
- Contrary positions are advocated to many of these principles by many sellers not anxious to see a reformed market with organized buyers.
- In implementing purchasing reform -- voluntary alliances or purchasing cooperatives -- listen to the buyers of health plans, not the sellers. Watch what effective buyers do today.

❑ **Insurance Reform:**

- Insurance reform is not free health care for all. It is not all that might be desired.
- Voluntary reforms will not accomplish universal coverage. Guaranteed or mandated benefits cannot by financed with voluntary contributions. Substantial subsidies required to put a reasonable minimum standard of health benefits within the reach of the working poor -- the typical uninsured American.
- Insurance reform can and should make insurance more secure, keeping insurance available and affordable as consumers get older and sicker, as we all inevitably do.
- Insurance reform can and will make the insurance market more stable and accountable.
- These are significant improvements over the status quo.

- **Specific issues in insurance reform.**

  This bullet point and subpoints likely to be cut due to time constraints. These are more detailed examples and are more likely to benefit staff than members.

  - Self-funded association plans (illegal multiple employer welfare arrangements that currently comply neither with ERISA or state insurance law) are seeking a grandfather clause to permit them to continue to operate with industry rating and other rules of the status quo. Exempting them from the rules of reform will increase costs to others and is against the general interest.
  - In setting requirements for self-funding (amending ERISA) remember original goals of ERISA -- to allow large, multistate employers to offer a uniform benefit plan nationwide. National insurance reform will accomplish this goal. Allowing an employer to self-fund is allowing an employer to be a community unto itself in community rating. Key question is how small can an employer be to be a community unto itself. The lower the ERISA self-funding threshold is set at, the greater the regulatory burdens -- more players to regulate. Those that choose to self-fund will be groups below the average cost of the entire community. The result will be higher costs for those within the insured community. Perhaps consider making self-funding a permanent election. Can't decide, "I won't share costs with you while my group is young and healthy, but let me join the insurance pool when my group is old and sick."
  - Allow consumer choice, including choice of limited panel managed care plans. To do otherwise is to require all consumers to buy smorgasbords, even if willing to take a lower cost limited menu. Any willing provider bills protect provider incomes. Consumers should be given a real choice between health plans offering the same benefits but permitted to innovate in how to deliver those benefits at lower cost and better results.
  - HIAA template -- should eligibility determination (underwriting) be done by insurers or by HIPC/alliance? The alliance.
  - Who should hold the group insurance certificate for HIPC/alliance members? The alliance.
  - Don't decide issues that can be left to business judgment of an effective HIPC/alliance, particularly if politics might force wrong answer.

- **Conclusion -- need for Federal insurance reform rules to assure level playing field across state boundaries, regardless of whether insured or self-funded, and regardless of the offeror, marketer, or sponsor.**

  - **Minimum steps for 1994.** Insurance reform with effective voluntary purchasing alliances is minimum that Congress must accomplish this year. Done right, these reforms would at least lay the groundwork so that the only additional reform necessary would be the overlay of an adequate subsidy mechanism to provide universal coverage.

- **Single set of rules.** Insurance reform must set a single set of reform standards applicable to all who sell, administer or sponsor health plans, whether insured or self-funded.
- **Special exemptions.** Do not grant special exemptions or exceptions or create private advantages in conflict with general reform principles or standards applied to the larger market.
- **Access.** All health plans, marketers, and sponsors must play by the same rules of access -- guaranteed issue (with a limited waiting period for preexisting conditions if the consumer has not been contributing to a health plan, but otherwise providing for full portability and continuity of benefits between health plans).
- **Rating.** All must play by same rules of rating -- modified community rate.
- **Portability and Continuity.** All must play by same rules of portability and continuity (no preexisting condition limitation or waiting period if consumer had prior qualifying coverage.
- **Fair administration and financial security.** All must play by same rules of fair administration and adequate reserves to protect consumers from arbitrary or capricious claims settlement or financial failure.
- **Thank you.** Consumers are counting on you to represent the public interest and to recognize and resist those seeking private advantage at the expense of the broader community.

Mr. DINGELL. Thank you, Mr. Winegarden.
The Chair now recognizes Mr. Coffman.

TESTIMONY OF MIKE COFFMAN

Mr. COFFMAN. Thank you, Mr. Chairman and members of the subcommittee. In my testimony I will walk you through the health insurance reform bill that I initiated this year in the State of Colorado, as well as discuss the lobbying practices of Golden Rule Insurance Company in response to my legislation.

In 1993, an employers coalition was formed in Colorado to address concerns with the health insurance industry. In Colorado many employers maintain that the growing power of purchasers is driving both the sharp drop in the growth of health care rates and the restructuring of the system. The coalition felt that reforms were needed to address the inequities in a small group market where many small businesses have difficulty in finding coverage.

This year, with the backing of the coalition and more progressive insurance carriers I introduced and passed a comprehensive small group insurance reform bill, House Bill 1210, that required health insurance carriers to provide guaranteed access to health insurance for anyone in a small group of 1 to 50. Following a one-time waiting period, no one could be denied coverage on the basis of any preexisting condition. So long as there was not a gap in coverage of more than 90 days, one would have portability of that coverage to other policies. A basic and standard benefit package has been designed by a commission established by the legislature.

Carriers offering small group policies will have to offer the basic and standard plans and provide guaranteed issue. These carriers can also offer other plans and will be able to set their own rates for all plans within an adjusted community rating structure. Adjusted community rating is to be phased in over a 3-year period in order to avoid broad rate swings.

Once it is fully phased in, the insured can only have rate differences on the basis of age and geography. Gender, health status or previous health claims cannot be used to determine rates. Mandating all carriers to offer the basic and standard plans served two purposes.

The first was that it established a uniform benefit level to provide a level playing field for the carrier's benefit and that of the insured. The second reason was to provide a greater degree of competition in the market place. Consumers would be able to readily compare different carriers in their ability to manage costs effectively because benefit levels would be comparable.

A companion bill, House Bill 1193, was designed as a cost-containment strategy to offset the potential increases created by guaranteed issue. It established a regulatory framework that encourages small businesses to band together in voluntary alliances for the purchase of health insurance. Through the voluntary alliances, these small businesses can enjoy the same leverage in obtaining discounts that large corporations have.

Golden Rule, along with other insurance carriers specializing in the individual market, took the strongest position against the bill. The initial draft of the bill insured individual carriers to provide guaranteed issue of basic and standard plans to individuals. Gold-

en Rule argued that they would incur adverse selection. Sick people not now insured and likely unemployed would gravitate to them.

Their belief was that individuals with chronic illnesses who left group policies would have no choice but to move to individual policies if they were no longer employable due to their health status. This issue had been largely addressed in my proposal by requiring small group carriers to offer conversion policies of the basic and standard plans. They further argued that Colorado had already established a subsidized uninsurable health insurance plan for high-risk individuals who would otherwise not get health insurance. That pool is limited to 2,400 people to assure stability and has a very limited financing mechanism to subsidize its policies. They were able to strike the unemployed individual from the bill while the self-employed individual remained.

My view of Golden Rule Insurance Company is that they are aggressive in the defense of the status quo in the health insurance industry because they fear that any significant change will eliminate their narrowly-focused market. In debating the merits of my legislation, I questioned much of the data they use from other States to support their arguments Colorado.

These "studies" which forecasted broad rate increases were used effectively in exploiting the fears that legislators had with the unknown consequences of health insurance reform. There seemed to be a very close linkage between Golden Rule and the American Legislative Exchange Council. The American Legislative Exchange Council participated in a fight against my legislation by producing position papers that were word-for-word that of Golden Rule's and sent them to legislators prior to key votes.

This greatly enforced Golden Rule's lobbying capability against my reform efforts. I have found the individual lobbying practices to their Colorado contract lobbyist Linda Kirscht to be neither unethical nor irregular, but simply aggressive and effective. In Colorado, one reason why Golden Rule has been extremely successful in thwarting any meaningful reform in the individual market is largely due to the fact that there are no powerful special interest groups that are an advocate for the individual in the insurance industry market. Reform efforts in the individual market are left vulnerable to the well-organized lobbying power of Golden Rule, where in the group insurance market there are business and labor organizations that have the power to move such reforms forward.

Health insurers are not eager for change, but some farsighted carriers see the handwriting on the wall and have come to the debate in a constructive way. My overall view of the health insurance industry is that reforms such as the one that I have introduced in Colorado are necessary to bring about equity in the system.

Health insurance carriers must be made to compete on their ability to manage health care costs and not on their ability to avoid risk. I would be reluctant to see the regulation of the health insurance industry move to the Federal level. States have succeeded in drafting comprehensive reforms effectively and should be entrusted to continue to do so as laboratories for a range of programs which best suit their unique needs.

Thank you, Mr. Chairman, and members of the committee.

[The testimony of Mr. Coffman follows:]

Testimony of State Representative Mike Coffman to the Oversight & Investigation Subcommittee of the Energy & Commerce Committee

Mr. Chairman and members of the committee. In my opening remarks I will walk you through the health insurance reforms that I have initiated in the State of Colorado as well as discuss the lobbying practices of Golden Rule insurance company in response to those reforms.

My work on health insurance reform in Colorado began in the 1992 legislative session. Colorado legislators began their discussion before the presidential election.

In 1992 I was the State House sponsor of Senate Bill 4, legislation which authorized for the State of Colorado to proceed with a study for universal health insurance coverage for all Coloradans.

The initial premise was for the State to approve a limited number of health insurance carriers to provide uniform benefit plans from which the public could chose. The study was essentially to be an actuarial analysis to determine the cost of such a program. Financing options would be provided from sources ranging from an employer mandate to public financing. Medicaid would be rolled into the plan under a waiver from the federal government. Money for the study was made available by a grant from the Robert Woods Johnson foundation. The study was to be completed by the summer of 1993 with legislation drafted for 1994.

Opposition to the proposal at that time was limited. Since the legislation was merely initiating the study to determine cost, legislators were willing to see what it would show.

In 1993 I had growing reservations about the need for a massive overhaul of the health care insurance system in Colorado that was then called for in Colorado Care. I felt the need to retain a market based system and preserve individual responsibility. I devised a plan in conjunction with a mainstream group of insurance carriers called the Colorado Group Insurance Association to revamp our state's health care system. There were four elements to this reform. The first dealt with provider reform in that it limited health care providers to the rates established under Medicare. The second was to require health insurance carriers to cover all preexisting conditions and to provide portability when changing carriers. The legislation also limited the rate of increase that a carrier could charge the insured at the time of any renewal. The third provision sought to control Medicaid cost by placing as many Medicaid recipients as possible in capitated managed care plans by contracting with private health insurance carriers. The last provision of the bill was to provide a system of universal coverage via an individual responsibility model. This would provide an incentive for individuals with the financial wherewithal to afford health insurance to have it. Should they elect not have it then a surcharge would be placed on their state income tax and that additional revenue would then go to help fund policies for the near poor.

The Colorado Group Insurance Association was instrumental in lobbying for the bill and generating public support. The business community seemed unsympathetic. The opposition came primarily from health care provider groups who hated the rate regulations. Large insurance carriers were also opposed because they felt that they would fare better under a managed competition approach similar to that of Coloradocare. Elements of the bill passed the State House but nothing survived the State Senate. Golden Rule insurance company did not play a significant role in the defeat of the bill although their lobbyist argued for the status quo and against the projected cost of reform.

In 1993 with the Clinton Administration moving forward at the federal level, our governor and the legislators supporting Coloradocare thought it best to wait and see what congress would do. Legislation to enact universal coverage in Colorado was postponed.

That same year an employers' coalition was formed in Colorado to address concerns with the health insurance industry. In Colorado, many employers maintain that the growing power of purchasers is driving both a sharp drop in the growth of health care rates and a restructuring of the system. However, the coalition felt that reforms were needed to address the inequities in the small group market where many small businesses have difficulty in finding coverage.

This year, with the backing of the coalition and more progressive insurance carriers, I introduced and passed a comprehensive small group health insurance reform bill, House Bill 1210, that required health insurance carriers to provide guaranteed access to health insurance for anyone in a small group of one to fifty. Following a one time waiting period no one could be denied coverage on the basis of any preexisting condition. So long as there was not a gap in coverage of more than ninety days one would have portability of that coverage to other policies.

A basic and a standard benefit package has been designed by a commission established by the legislature. Carriers offering small group policies will have to offer the basic and standard plans and provide guaranteed issue. These carriers can also offer other plans and will be able to set their own rates for all plans within an adjusted community rating structure.

Adjusted community rating is to be phased in over a three year period in order to avoid broad rate swings. Once it is fully phased in the insured can only have rate differences on the basis of age and geography. Gender, health status or previous health claims cannot be used in determining rates.

Mandating all carriers to offer the basic and standard plans served two purposes. The first was that it established a uniform benefit level to provide a level playing field for both the carriers benefit and that of the insured. The second reason was to provide a greater degree of competition in the market place; consumers would be able to readily compare different carriers in their ability to manage cost effectively because benefits would be comparable.

A companion bill, House Bill 1193, was designed as a cost containment strategy to offset the potential increases created by guaranteed issue. It established a regulatory framework that encourages small businesses to band together in voluntary alliances for the purchase of health insurance. Through the voluntary alliances these small businesses can enjoy the same leverage in attaining discounts that large corporations have.

Golden Rule, along with other insurance carriers specializing in the individual market, took the strongest position against the bill. The initial draft of the bill required individual carriers to provide guaranteed issue of basic and standard plans to individuals. Golden Rule argued that they would incur adverse selection. Sick people not now insured and likely unemployed would gravitate to them. Their belief was that individuals with chronic illnesses who left group policies would have no choice but to move to individual policies if they were no longer employable due to their health status. This issue had been largely addressed in my proposal by requiring small group carriers to offer conversion policies of the basic and standard plans.

They further argued that Colorado had already established a subsidized uninsurable health insurance plan for high risk individuals who could

not otherwise get health insurance. That pool is limited to 2,400 people to assure its stability and has very limited financing mechanisms to subsidize policies. They were able to strike the unemployed individual from the bill while the self-employed individual remained.

My view of Golden Rule insurance company is that they are aggressive in the defense of the status quo in the health insurance industry because they fear that any significant change will eliminate their narrowly focused market.

In debating the merits of my legislation I questioned much of the data they used from other states to support their arguments against my reforms for Colorado. These "studies" which forecast broad rate increases were used effectively in exploiting the fears that legislators had with the unknown consequences of health insurance reform.

There seemed to be a very close linkage between Golden Rule and the American Legislative Exchange Council. The American Legislative Exchange Council participated in the fight against my legislation by producing position papers that were word for word that of Golden Rule's and sent them to legislators prior to key votes. This greatly reinforced Golden Rule's lobbying capability against my reform efforts.

I have found the individual lobbying practices of their Colorado contract lobbyist, Linda Kirscht, to be neither unethical nor irregular but simply aggressive and effective.

In Colorado, one reason why Golden Rule has been extremely successful in thwarting any meaningful reform in the individual market is largely due to the fact that there are no powerful special interest groups that are an advocate for the individual in the individual insurance market. Reform efforts in the individual market are left vulnerable to the well organized lobbying power of Golden Rule where in the group insurance market there are business and labor organizations that have the power to move such reforms forward.

Health insurers are not eager for change. But some farsighted carriers seeing the handwriting on the wall have come to the debate in a constructive way. My overall view of the health insurance industry is that reforms such as the one that I have recently introduced in Colorado are necessary to bring about equity in the system. Health insurance carriers must be made to compete on the basis of their ability to manage health care cost and not on their ability to avoid risks. I would be reluctant to see the regulation of the health insurance industry move to the federal level. States have succeeded in drafting comprehensive reforms effectively and should be entrusted to continue to do so as laboratories for a range of programs which best suit their unique needs.

Thank you Mr. Chairman and members of the committee.

Mr. DINGELL. Thank you very much for your testimony, gentlemen.

The Chair recognizes first the gentleman from Colorado for such questions as he chooses.

Mr. SCHAEFER. Thank you, Mr. Chairman.

Representative Coffman, I understand that Golden Rule generated a great deal of opposition to your legislation, as per your testimony. Can you tell us how many of the amendments in opposition to your legislation were written by Golden Rule as opposed to other companies or other interests? Do you have any link on that at all?

Mr. COFFMAN. Yes, Representative Schaefer, I think that they did write an amendment in the Appropriations Committee that largely struck the bill and instituted reforms that they concurred with. That was reversed on the House Floor. I will say that the other carriers that represented that individual market were also heavily involved in the lobbying. I think State Farm was very effective in the sense that their corporate headquarters is in northern Colorado and I think they might have had more say than Golden Rule on some of the significant issues of the bill.

Mr. SCHAEFER. Of course, this is common practice in all State legislatures, as well as in Congress on lobbying efforts.

I understand that substantial reform has taken place in the small group health insurance market in Colorado due in large part to your efforts and that of Senator Schroeder, but that similar forms have not occurred in the individual market. Can you give us any reasons for that?

Mr. COFFMAN. I think that the central reason I don't think there is a—when you talk about the small group market you have business organizations and labor organizations that certainly coalesced around my bill in terms of getting it forward, but in terms of the individual market there is no, I think, special interest groups out there that is well organized to represent them as an advocate. I think that is a reason why I think the individual is left out in many States, because there is not that organized support group for it.

Mr. SCHAEFER. An April 10, 1992 article in the Denver Business Journal, said "Despite widespread backing by the insurance industry, a key health care reform bill has been gutted after intensive lobbying of Colorado legislators by Indianapolis-based Golden Rule Insurance Company."

I understand this refers to legislation about which you testified. Would you agree that the legislation was gutted by Golden Rule or were there other insurance companies involved in this?

Mr. COFFMAN. I would have to say there were other carriers involved. I don't think it was just Golden Rule. State Farm, the Senate President was from northern Colorado where State Farm was based, as well as a number of other legislators in that delegation, and there was considerable influence I think in that particular area. I think they were referring to the Appropriations Committee during that time frame. I think Golden Rule led the attack in the Appropriations Committee, but that was reversed on the floor and we essentially put the majority of the bill back together.

Then I saw the handwriting on the wall in terms of the opposition and chose to amend the individual from the bill looking down the road. Golden Rule did not—once the bill got out of the House in terms of the small group reform—did not have further opposition to those reforms when it was in the State senate. There were a number of negotiations that took place.

Mr. SCHAEFER. But Golden Rule wasn't the only player?

Mr. COFFMAN. No.

Mr. SCHAEFER. For any of you gentlemen, from the thrust of the testimony that we have heard today, and at our June 29 hearing, it would appear that Golden Rule's actions represent a rather extreme example of practices that are unfair to insurance consumers. I want to find out whether this is really an extreme—your comments—is this something typical of only Golden Rule or is it other health insurance companies as well that are involved here?

Any of you gentlemen.

Mr. WINEGARDEN. We have talked about two different things this morning in connection with Golden Rule or the individual insurance market. One is lobbying activities, and I have to say that in our State my experience in 1992 was unique. I have never had a company behave in that way nor has Golden Rule behaved in that way since in our State.

The other is in the conduct towards consumers in the insurance market. Perhaps as insurance commissioner, our office hears the complaints of consumers more than most officials in State government. We are aware of the weaknesses in the current regulatory structure and rules of the game in health benefit plans. Golden Rule is not the only company to play by those rules in the individual insurance, and it has resulted in a marketplace for consumers in which people who do not have access to group insurance have either no choices or bad choices, and frequently you will see situations in which insurance is easy to get when you don't need it and if you think that is a good bargain, that is a judgment. I don't think that is good value for consumers and it is impossible to get when you do need it.

In the individual insurance market, individual commissioners have special concerns about a practice called post-claims underwriting in which a consumer has done everything possible and that you could reasonably ask of a reasonable consumer to protect their interest and take responsibility for financing their own health care. They have bought an insurance product and believe that they have coverage, but when a claim comes in, an insurance company reviews should we have written this person to begin with. In failure to have clear guidelines, even using tools like we have in the life insurance market like an incontestability period after 6 months or after a year you couldn't argue about whether it was covered or not, consumers are often left after the fact not having coverage for claims that they reasonably believe that they do.

I want to distinguish that from the instance in which medically unnecessary or inappropriate care is delivered because somebody has to care about the money. There is a limited amount of money that either individuals, government or employers have to spend on health care. We don't want to waste our dollars, but in managed care, much of what passes for managed care is in fact managed

cost and does not address value and service to the customer. That is why I have emphasized the need to provide better information to customers on value and to provide them the ability to vote with their feet.

Mr. SCORSONE. Of course, I can only speak about Kentucky's experience, but I would say that the lobbying activities of Golden Rule in Kentucky did stand out as quite different than the rest of the industry. In terms of the substantive issues, I would say that their position against modified community rate and the guaranteed issue was clearly far out there. It was not the industry norm. They were much more willing to accept those changes in terms of reform.

I think the antidote to this in Kentucky was similar to what happened in Iowa, which is that once we exposed that the information that was being passed around by Golden Rule was inaccurate, it had the opposite effect on Golden Rule's position and they were—one of the things that they were so upset about was the removal of the guaranteed loss ratio in the statute which is something that they had pushed for a couple of years before. Once it became known that Golden Rule was adamant about keeping this in there, they built up more steam. So I think bringing the issue to light and giving more information on what was going on helped us tremendously in Kentucky.

Mr. SCHAEFER. I would follow up and ask have you, Mr. Coffman, or Mr. Scorsone, been sued or threatened with legal action?

Mr. COFFMAN. I have not.

Mr. SCORSONE. Not yet.

Mr. SCHAEFER. Mr. Winegarden, per your testimony, did Golden Rule follow through on its threat to do whatever necessary to get your department to back its minimum loss ratio proposal?

Mr. WINEGARDEN. It did not, and I think one of the reasons why is that the threat was immediately exposed and, frankly, the topic became scorched earth, it was not something that public officials in Iowa could support because it would then be viewed by the public as having given in to an inappropriate threat that was not consistent with the conduct of public policy in the State of Iowa.

Mr. SCHAEFER. One other question Mr. Chairman. My time is running out. One criticism we have heard is that Golden Rule has actively resisted various State health insurance reforms despite having a small presence in the State in terms of premiums. I would be interested in hearing whether this situation exists in your respective States.

Mr. SCORSONE. Yes, sir. I believe in Kentucky I indicated that their share of the market was only about 2 percent, so pretty small in terms of the overall picture.

Mr. COFFMAN. Mr. Schaefer, I think in terms of the—they have minimal—I am not sure if they have a presence in the small group market. In the past they have challenged or resisted small group reform efforts. I don't think they resisted mine that hard this time. They fought the individual reforms for which they do have a presence in Colorado.

Mr. WINEGARDEN. In Iowa, the company in 1992 had approximately one-half of 1 percent of the market. That perhaps even more emphasized the point that it was seeking special advantage for a relatively small share of the market and to expect to dictate

to the State insurance commissioner what public policy should be. When we reviewed the proposal we felt it to be contrary to the best interest not only of Iowa consumers but the best interest of Iowa insurance companies that had a much larger share of the market place.

Mr. SCHAEFER. In any of you gentlemen's opinion, does Golden Rule target its insurance policies only to the young customers? Can you answer that at all?

Mr. SCORSONE. I don't feel comfortable answering about their marketing practices.

Mr. SCHAEFER. What about cherry picking? Do any of you have an opinion on that? Do they operate in that manner?

Mr. WINEGARDEN. I think that that is a general condition within the individual market as a whole. I want to counterbalance that by saying that there are some problems in individual insurance that are legitimate concerns for companies. It is more expensive to administer an individual insurance policy where you have to find the willing and able individual buyer and you have to collect premium from a hundred different individuals instead of in the group market one employer for a hundred different individuals.

That said, I think that one of the problems that you have heard from consumer after consumer in considering health care reform is that people who need health care coverage, the most have lack of access to it. And when you lose access to group insurance the choices, if you are buying as an individual under most markets today, is not good. And it is the individual market and access for individuals losing access to group coverage that is perhaps in the biggest need of reform.

Mr. COFFMAN. Mr. Schaefer, I think that their argument to me was that if they had to take on risk, if they had to take folks with preexisting conditions, that it would in fact greatly raise costs so they did consistently make that argument.

Mr. SCHAEFER. It is my understanding in reading how this company does exist that some two-thirds of their premiums are under the median income of some $35,000 a year so, therefore, I would imagine that they certainly do take a lot of risk with these types of individuals. I yield back my time Mr. Chairman.

Thank you.

Mr. DINGELL. The time of the gentleman has expired.

The gentleman from Ohio, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. DINGELL. The Chair notes that the Chair is recognizing Members for 10 minutes because of the complex questions and fairly limited attendance.

Mr. BROWN. I would like to talk about the Kentucky legislation if we could. You had said the legislation makes it illegal for insurance companies to refuse to insure sick people, requires State approval for rate increases, forbids insurance companies from basing premium differences on a person's health or a person's occupation. In addition it allows, it requires that health insurance plans be renewable except in cases of fraud or failure to pay premiums; all those are correct?

Mr. SCORSONE. Yes.

Mr. BROWN. You also said that there are more kinds of lenient elements of the bill, if you will, that the legislation still permits an insurer to exclude or limit coverage for up to 6 months before a policy takes effect?

Mr. SCORSONE. The preexisting condition clause can be up to 6 months, but if you have one policy in effect in terms of being able to transfer to another policy, if you basically have come through the 6 months that holds for other policy. The only problem would be if there is a break of 60 days.

I think Colorado, it is a 90-day break. In Kentucky, we would only permit a 60 break, so if you don't break within those 60 days, it is continuous even if it is Medicare or Medicaid coverage that you are using to extend.

Mr. BROWN. The bill also allows insurers to take into account factors such as age, geography, family size——

Mr. SCORSONE. Yes. The age is limited to 300 percent, which is pretty much the standard in the industry.

Mr. BROWN. The law includes a years lag time before companies have to offer standard plans?

Mr. SCORSONE. Yes. The actual insurance reforms kick in in July 1995. We have done this as a stopgap for this interim year. We are allowing individuals who may for example lose coverage because some companies might leave the State, we are allowing them to join into the State employee program to take advantage of the State pool, if you will, that is in effect now for this interim year.

Mr. BROWN. So, obviously, it is a very substantive bill with teeth in it that will matter in terms of people who have had trouble buying insurance before, but even with all that, there is plenty for health insurance companies to, in many cases, not be particularly displeased with. Why was Golden Rule lobbying so hard against it and why did they go to court against it?

Mr. SCORSONE. We don't know that I am the best person to ask as to what their motivation was. We think we can have a health care market in Kentucky that can be profitable for companies that run a good show. We don't think we threaten the profitability of the industry at all. We have adopted some rules that make the market a little more consumer-friendly, if you will, and I think in that respect maybe the company felt threatened by that change.

Mr. BROWN. Tell us about the Consumer Reports' 1990 articles about insurance, specifically about Golden Rule and what they found about denial rates.

Mr. SCORSONE. I am not familiar with that Consumer Reports article, so I really couldn't address that. In terms of the complaints, the only thing I can testify to is the complaints ratio in Kentucky which is much higher than the standard in the industry in Kentucky.

Mr. BROWN. Consumer Reports said that Golden Rule rejected 20 to 30 percent of all applicants who are 65 and as many as 50 percent of those who are 70. They also concluded that some companies no longer offer low deductibles. Golden Rule's chief actuary at that time said, if somebody can afford to buy a product, he can afford $1,000 deductible. If you don't want first dollar coverage, it may cost $80 to take care of a $50 bill. Does any of that surprise you?

Mr. SCORSONE. I haven't read the article. I would rather not continue on that .

Mr. BROWN. Talk to me about some of the tactics. With what is going on in health reform today in Congress and a lot of us that strongly support coverage that can't be taken away, universal coverage for everybody that can't be taken away, it is pretty disturbing to see what has happened with the debate and with the Harry and Louise ads.

What has Golden Rule done specifically, and from some of the television ads to some of the direct contact with legislators to other things they have done in Kentucky, to fight this legislation and to fight any kind of health care reform and to create an environment that might poison the voters, your constituents' minds about health care reform?

Mr. SCORSONE. I think what legislators found most offensive about the campaign and the lobbying efforts, and everybody agrees Golden Rule, as does any other entity, has a constitutional right to lobby and to campaign for their position, was that they consistently were talking about issues that were not in the bill and things that may have at some point been discussed, but were not actually in the measure and were using that as an argument to defeat the bill.

I think legislators found that particularly offensive because it was not in sync with what was going on. If you come up with a bill and there is no resemblance to what some of the original thoughts have been, you wouldn't expect a campaign to center upon things already discarded. The legislators complained that they received numerous unsigned letters from policyholders in their area and then they would contact the policyholders and say you have written me this letter on this issue. It was an unsigned letter and the policyholder would say that is not my view on this matter.

Mr. BROWN. Unsigned—unidentified you mean.

Mr. SCORSONE. They were Golden Rule members. They were Golden Rule policyholders and they talked about the bill and certain points about it and when a legislator would call that person and say is this how you feel on the issue, they would say no.

I don't know what went on in terms of soliciting the authority to send a letter and what was said to procure that, but the bottom line is that when legislators confronted the constituents that letter did not jibe with the constituents comments or feelings about the issue and that some legislators found very offensive.

Mr. BROWN. Let's talk about that in light of health care here and this is perhaps less about Golden Rule and more about that. It is so common nowadays that what you say, this kind of misinformation that people say, vote against the health care bill. One of the favorites is don't vote for that bill because if I pay my doctor, my doctor will go to jail. That is one that I hear frequently.

People believe radio talk show people more than they believe their State legislator. I say that is not what the bill says. The bill says if a doctor gets paid by an alliance in the old form of the bill and paid individually by the patient, that is fraud, as it should be.

Are you seeing a lot of that? Are you seeing, beyond the example you gave, a lot of misinformation? And if so, is it coming from Golden Rule? Do you know where it comes from in addition to that one letter, the misinformation you are seeing?

Mr. SCORSONE. I think in Kentucky the experience was primarily from the Golden Rule Company in terms of policy holders. It is a battle with the public and public perception of what is going on.

We had the same problem in Kentucky I think that is going on in Washington which is that everybody is not in sync and nobody is talking about the same issue or the same bill. If you had the luxury of being focused on one particular measure where you could really focus attention of the public profile on what is in the bill or isn't in the bill that it makes it a lot easier. When you have discord between parties and between executive and legislative, which we had in Kentucky, it makes it extremely difficult to have a focused message to the public and that is what we need.

Mr. BROWN. You mentioned those letters that were sent. Are you seeing a lot of sort of pseudo grassroots lobbying by the corporation where we are seeing again on health care reform example after example of pharmaceutical companies sending letters to their customers asking them to write letters to us. So we get letters from a pharmaceutical company really, although they are written by individuals or oftentimes smokers will write letters that the tobacco companies ask them to send to us.

Has Golden Rule done that kind of pseudo grassroots lobbying to you in addition to those letters?

Mr. SCORSONE. Phone calls and letters have been the extent from that company. I don't know whether the State experience has been any different.

Mr. BROWN. Anybody else want to comment on the grass roots lobbying kind of stimulated by corporations where the corporation will write the letters and mail them to their customers, employees, and ask them to sign them?

Mr. COFFMAN. I think we were fortunate in that we had a number of mainstream insurance companies that saw the handwriting on the wall and said we have got to do something here if we can reform the system so the system isn't scrapped down the road. Actually, there was some grass-roots participation on the other side where all the insurance agents and members of the Colorado Group Insurance Association found out who their legislator was and called and were aggressive about it. I think we were more aggressive than Golden Rule was on the side of reform in Colorado. And I didn't see that done in Colorado during this last session.

Mr. WINEGARDEN. We have seen problems with regard to tactics in health care reform. I have spent approximately the last 2 years as our Governor's public policy expert on health care reform and have done considerable speaking and listening around the State. Speaking with average Iowans, they have a far more balanced and skeptical view of scare tactics that are used by various participants, not just the insurance industry—health care providers and others tell their side of the story.

A republic, a representative democracy, demands leadership of its leaders. You are expected to sort through the special interest assertions to find the common thread of public interest and exercise leadership. That is the hard job that has been given to you by the people and it is not going to be fun on health care reform because there is fear, there is distortion on the topic and it comes from several sides of the issue.

Mr. BROWN. Thank you. Mr. Scorsone.

Tell us about the Kentucky Legislative Ethics Commission complaint that they filed against Golden Rule for refusing to disclose how much it spent on their media campaign and its aftermath.

Mr. SCORSONE. It is still an ongoing process. We have just created the Legislative Ethics Commission, so it is a new entity on the scene in Kentucky, but it has some powers and it is aggressively pursuing information from Golden Rule in terms of its lobbying activities. The main issue has been their TV ad campaign that they have refused to give any information on that, claiming that it was not a lobbying activity.

The commission has filed an official charge. We have not received a response yet from Golden Rule. The Ethics Commission has the ultimate power of revoking the registration of Golden Rule and prohibiting it from doing any lobbying in Kentucky. I am not saying that that is going to be the outcome, but it is certainly one of the powers the commission has in this case.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. DINGELL. The gentleman from Texas, Mr. Barton.

Mr. BARTON. I thank the chairman.

Before I get into my substantive questions, I have some personal questions for the gentleman from Colorado.

Mr. Coffman, is your district in Congressman Schaefer's district, by any chance?

Mr. COFFMAN. Yes, it is.

Mr. BARTON. He says up here that he is viewed as the most effective and beloved legislator in the history of the State of Colorado. Is that true? Do his constituents share that view?

Mr. COFFMAN. There is no doubt. That view is probably shared nationally.

Mr. BARTON. I just wanted to see if he was being truthful up here. I am glad to know that that is a true statement.

I do want to ask—before I ask my questions I think it is only fair that the panel know that I am not a proponent of the Clinton health care initiative. I support the Rowland-Bilirakis incremental approach. That is where I am going to be coming from when I get to what we need to do for health care.

I do want to ask the representative from Colorado, as indicated in your opening statement and in Mr. Brown's questions, that there is some sort of an inquiry against Golden Rule because of their television campaign. I assume that it is not illegal for them to have television ads that specify a position in support or opposition to pending legislation; is that true?

Mr. COFFMAN. I yield to the representative——

Mr. BARTON. I mean Kentucky.

Mr. SCORSONE. Absolutely not. It is not a question of whether it can be done or not; it is a question of disclosure. That is what the ethics are all about and the requirement that they disclose the amount that they spent on lobbying.

Mr. BARTON. With regard to that, does Kentucky have a cap on what can be spent so it is simply the fact that they refused to disclose what they spent, not that they did it and how much—if they had spent a million dollars, it would be unusual but not illegal. So the fact that they refused to disclose——

Mr. SCORSONE. As far as I know on the issue of TV advertising, that is what it is.

Mr. BARTON. The deputy—First Deputy; is there a second deputy by the way?

Mr. WINEGARDEN. Only one.

Mr. BARTON. You indicated, and I want to make sure that I get this correctly, that a representative of Golden Rule came into your office and threatened you or threatened one of your employees with regard to what they wanted in the reform package that was pending before the legislature—it wasn't even a reform package, your commission had the right to unilaterally do some things.

Mr. WINEGARDEN. It was by a phone call to myself. One of my duties as First Deputy Commissioner is legislative liaison and chief policy analyst for the Commissioner of Insurance and I was responsible for the division legislative package.

We had a prefiled bill sponsored by the Division of Insurance which included two major pieces, one confirmation of the rerating authority for the commissioner to review not only the initial rates filed by a company, but also the subsequent increases filed by a company, and that was specifically done to avoid the potential of threatened litigation by Golden Rule contesting what had been historically exercised rerating authority by the commissioner.

Second, we also had in the bill the small group insurance reforms that have been described by the other States and the lobbyists for Golden Rule asked for two things: either the Commissioner's support for minimum guaranteed loss ratio as a substitute for the rerate authority that was included in our bill or threatened an all-out opposition lobbying campaign.

Mr. BARTON. I have an editorial comment on that. I am assuming that the First Deputy Insurance Commissioner is an appointed position, that it is not elected; is that correct? In other words, the governor or commission appoints you?

Mr. WINEGARDEN. The commissioner is appointed by the governor and I work at the leisure of the commissioner and I am not a civil service protected employee.

Mr. BARTON. So you are not voted on by the people of Iowa?

Mr. WINEGARDEN. That is correct.

Mr. BARTON. I am voted on by the constituents of the 6th District of Texas. Every town meeting somebody comes up and says if you don't do this, I won't vote for you. They say if you don't do this. I am going to work against you. And sometimes they say if you don't do this, I am going to get all these other people.

Believe it or not, I have even had people come to my office representing big groups of people saying if you don't do this, we are not going to support you financially, and we are going to do this. I could take those to be threats or I could take them to be hot air. I could take them to be legitimate concerns, but I don't take them as something that is illegal.

These people are exercising their First Amendment rights to tell me—I don't like people to call on the telephone and threaten hell and damnation if they don't do exactly—but I don't think it is illegal. Once that occurred, and I will admit that is not the appropriate way to approach the First Deputy Commissioner of Insurance in Iowa, but you indicated in response to a question from Con-

gressman Schaefer that once you exposed that conversation, they didn't follow up; is that correct or incorrect?

Mr. WINEGARDEN. That is correct, sir.

Mr. BARTON. It could be because they were bluffing to begin with. It could be because in your eloquence, in your intelligence and your humility that you convinced them that that was inappropriate action or it could be they knew they would get their head handed to them on a platter if they tried to follow up, but the fact is they didn't follow up?

Mr. WINEGARDEN. They didn't follow up.

Mr. BARTON. You seem to be an intelligent fellow and I think anybody from Iowa has to be intelligent to live there because it is a great State.

I don't support community rating because I think if I am in shape and eat health foods and run every day and never drank whiskey or smoked cigarettes and the fellow next to me is the same age and he drinks like a fish and smokes like a train engine and never exercises, both his parents had heart attacks before age 40, if we show up and asked for individual insurance, I think the insurance company ought to be able to charge a different rate.

I think there is an individual responsibility factor. I don't think the other fellow shouldn't be insured, but I think he should have to pay a higher premium.

Do you disagree with that?

Mr. WINEGARDEN. I don't disagree with your statement as to there should be a time of individual responsibility. However, that is not the way the current insurance rating system works. The current insurance system rating does not look at the exercise of choice by consumers with regard to their health choices but looks at results.

People can end up with claims or experience that is totally connected to random events. Bad things happen to good people. You do not choose to get multiple sclerosis. In fact, our Iowa insurance reforms do substantially limit or eliminate the use of experience in differentiating between the rates charged to different consumers.

Mr. BARTON. What does that mean in layman's terms?

Mr. WINEGARDEN. It means community rating of experience. We do allow modifications by age, by geographic location, by family composition and we contemplate if an acceptable methodology is presented to us allowing variation based upon demonstrable matters of choice that have a significant impact upon rates and that can be objectively determined; that is that they are not a matter of subjective judgment.

Mr. BARTON. The Golden Rule representatives have been to see me. They didn't threaten me. I asked them a lot of fairly tough questions.

They indicated on this community rating issue that they support a creation of a catastrophic risk pool similar to an assigned risk pool in automobile insurance where going through the methodology that I think you are contemplating in Iowa you put these people into this risk pool.

They still get insurance and evidently it is similar to what you have done in Colorado except you limited it to 2,400 people statewide and that by doing that you don't raise insurance claims to ev-

erybody as high. They claim it would cause a 1 percent raise in the general pool. In this newer, gentler form, have they been to see you and discussed that proposal?

Mr. WINEGARDEN. Iowa is one of the first States to adopt a high risk pool as insurer of last resort for people who are uninsurable under the current rules of the commercial market place. The rules and the financing mechanisms for comprehensive health association in Iowa are as follows: consumers pay 150 percent of standard rates, get a less favorable policy as far as benefits are concerned, and it is financed by an assessment based upon market share in which insurance companies deduct from their premium tax payments to the State the assessments necessary to subsidize that high risk pool. Iowa has been serving through its comprehensive health association approximately 2,300 individuals on an annual basis relatively flat and stable. The rates are, frankly, unaffordable for the typical person. Insurance reform alone will not assure that people have coverage.

I mentioned previously that subsidies are necessary in order to address the typical person who is uninsured. Does that cost show up to the public? Absolutely it does. It has resulted in approximately a $3 million loss on an annual basis to State premium tax revenues and shows up in higher insurance premiums across the board.

In discussing community rating, Iowa has not adopted pure community rating; that is, eliminating age as a rating factor. One of the reasons is that, again, all insurance does is average what you tell it to average over whatever group you tell it to average. Most insurance companies I have spoken with believe that so long as they know what the rules are and that the standards are clear, and that everybody plays by the same rules, they think they are good enough to succeed under a reform system or at least they are willing to try.

With age rating, unless you are willing to do the subsidies, however, if you go to pure community rating, you end up with wealth transfers in the wrong direction. If you look at the typical uninsured person, it is the young, low income worker. The poor are covered by Medicaid. The older worker, and we are only talking about people under age 65 because, of course, Medicare covers over age 65—on average, the older worker has higher income and greater assets and actually greater willingness to pay for health care.

If you average rates over all workers 18 to 65, what you end up doing is dramatically increasing costs for young workers and lowering costs for older workers. The break-off point depending upon the State and the demographics is somewhere on the order of about 45, and you actually lose voluntarily-contributed dollars to the system because if you look at the rates of insurance, older workers have a dramatically higher rate of voluntary coverage.

Unless and until the Federal Government or the States are willing and able to provide substantial subsidies based upon income, I do not personally support the elimination of age as a rating factor. Once you do subsidies on the public side through a tax mechanism to account for ability to pay, I think that you do not have to take age into account and could have pure community rating.

Mr. BARTON. My time has expired.

I am interested in this but the red light means that you need to make the answer a little shorter. I might say that Fred Grandy, a good friend of mine, and I know he ran against the man you are working for, but he is a very knowledgeable person on health care here, not quite as good as Congressman Schaefer who is the best in the Nation, but fairly good. I yield back to the chairman.

Mr. DINGELL. The time of the gentleman has expired. The Chair recognizes himself.

Mr. Scorsone, newspaper accounts of Golden Rule's lobbying indicates that the company sent letters to its policyholders telling them that the reform bill would double their premium and that, "Kentucky lawmakers are ready to hand control of your health care over to bureaucrats in Frankfurt. Do you want these same people who fix pot holes in charge of Kentucky health care?"

That is like something I have heard as we have dealt with the health care business here in Washington. We seem to have heard the same characteristics before then. But neither you nor anyone else could find any documentation, I believe, to support these allegations, could you?

Mr. SCORSONE. No, Mr. Chairman.

Mr. DINGELL. On what basis did they make the statement that health care charges would double?

Mr. SCORSONE. The only logical way that I can explain this away is that some of the original thoughts and proposals were to go to a pure community rating, which was not adopted. Rather we went to a modified community rating.

I think they were using New York as an example on the pure community rating and try to analogize it to our work in Kentucky, but in fact the bill that we pushed and the leadership pushed clearly did not adopt the pure community rating but the modified, so it was not in sync.

In terms of turning over health care to the bureaucracy, we empower the consumer with our legislation. We empower the consumer with a lot of data in terms of health care analysis on providers and cost quality and outcomes, but also I think by creating an alliance, consumer-controlled alliance to really give the individuals clout in the marketplace, I think it was very much pro-consumer and pro-individual kind of legislation.

Mr. DINGELL. Now Golden Rule's lawsuit against Kentucky asks that none of the provisions of the new law go into effect; is that so?

Mr. SCORSONE. That is correct, Mr. Chairman.

Mr. DINGELL. What will be the effect on Kentucky's consumer residents if your reform measures are further delayed by this legislation?

Mr. SCORSONE. It is clear that it would hurt Kentuckians dramatically.

First of all, there is no need to delay a lot of the stuff in the bill that doesn't have to do with insurance reform because that is not an issue Golden Rule has taken on in terms of data, medical education, et cetera. But to delay even further the reforms means it will be even more difficult for the 400,000 or so Kentuckians who are not covered by health care to get any kind of health care.

Mr. DINGELL. Has anyone else, in the insurance business or out, joined Golden Rule in its legal actions against your State or in their lobbying efforts?

Mr. SCORSONE. Not in the lawsuit. In terms of lobbying, there is a dramatic difference in terms of both style and substance between Golden Rule and the other insurance providers.

Mr. DINGELL. I heard a quote from Mr. Masten Childers, II, the Secretary of State Cabinet for Human Resources in Kentucky. He said that Golden Rule was essentially claiming "a constitutional right to gouge the citizens of the State." Do you agree with that?

Mr. SCORSONE. Those were Masten Childers' words and I don't want to duplicate his words, but there is clearly an inference I think could be made that Golden Rule wants kind of a free rein to profit at the expense of consumers, and I don't think Kentucky approves of that and I think our reform legislation is a strong statement that we don't want that kind of operation in Kentucky.

Mr. DINGELL. Thank you.

Mr. Winegarden, I have some questions for you. The more we examine this company, we see two drastically differing corporate personas. We see many State officials' view of this as the quintessential health insurance company whose practices make reforms imperative and we see Golden Rule's view of an "exemplary corporate citizen," as a "mom and pop" operation fighting a lonely battle against the forces of Big Brother that would rob its policyholders of freedom of choice and force their premiums sky high.

I take it from your testimony that Golden Rule didn't appear to you to be seeking out the less fortunate, but rather that they were a company that was providing services to those best able to pay and those exposing the least risk to them. What conclusion am I to come to on this matter?

Mr. WINEGARDEN. I think the letter is appropriate. The current rules of the market pay profits to those that are best skilled at avoiding risk rather than paying profits to those that best spread risk, manage that risk and provide service to the consumers. That is playing by the rules of the game, and I think that we have to take responsibility as public officials to reshape those rules so that future profits are paid for behavior that is consistent with the public interest.

Mr. DINGELL. Let's take a look at some of the ways that Golden Rule conducted its business and let's look at the effect on policyholders. Let's focus first on the subject of loss ratios, a matter you discussed in your statement, a subject Golden Rule will discuss later today. The loss ratio is a percentage of premium dollars that are returned to consumers in benefits.

Mr. WINEGARDEN. It is the percentage of the total premium dollar that is paid back in benefits, although the calculation is more complex.

Mr. DINGELL. So that if a company has a loss ratio of 60 percent, a company uses 40 percent of the money of the policyholders to pay in premiums to cover its expenses and the balance remains as profit; is that right?

Mr. WINEGARDEN. Forty percent would be the administrative expenses of the company, including marketing, including distributions other than payments to consumers; that is correct.

Mr. DINGELL. I come to this equation.

A company receives X amount in premiums. The loss ratio would be the percentage of that that they use in paying for the services that their health care would provide to their shareholders or to their insureds; is that right?

Mr. WINEGARDEN. That is correct.

I would also like to point out that it is not just profits that you have to look at, particularly in a closely-held company. The owners or the officers of the company may not care whether it is paid out in profits on the accounting side or whether it is paid out in high salaries or other mechanisms.

Mr. DINGELL. I forgot to mention salaries. Salaries would fall under the administrative overhead.

Mr. WINEGARDEN. Yes, sir.

Mr. DINGELL. So that it can be said that the lower the loss ratios, the higher the company profits would usually be; is that right?

Mr. WINEGARDEN. The higher the total of profits and administrative expense and other things and that is why just the line item of profits may not tell you everything you want to know, but I guess in common parlance that would be the expected result.

Mr. DINGELL. Golden Rule was seeking a minimum guaranteed loss ratio and they indicated that that was a way to keep the premiums down. I gather that that would occur when an insurance company agrees to pay back a certain minimum percentage of the money it collects in premiums and to pay that back to policyholders for claims when people get sick?

Is that the practical result of it?

Mr. WINEGARDEN. Yes, sir. Golden Rule proposed a figure of 55 percent of this minimum loss ratio. At that time the average loss ratio in the Iowa market was 79.89 percent looking at companies representing 97 percent of the market. It was lower, 67 percent when the top writer, Blue Cross/Blue Shield, which has lower total administrative burden, is taken out. They are a large writer that does individual business as well. And it was 74 percent if you looked at all Iowa domestic carriers. So, in essence, Golden Rule was promising to return two-thirds of the average market loss ratio and calling that reform.

Mr. DINGELL. Would you give me the numbers again?

Mr. WINEGARDEN. We had of the top 109 health insurance companies representing 97 percent of the Iowa market, the loss ratio was 79.89 percent, almost 80 percent. If you excluded Blue Cross/Blue Shield, which is the largest writer in the State, and unlike many large insurers, writes both large group, small group and individual and therefore can spread its administrative costs over the entire market, the average loss ratio was 67 percent. If you looked at only Iowa domestic insurance carriers, the average loss ratio was 74 percent in that individual market.

Mr. DINGELL. Seventy-four percent is when you exclude the Blues?

Mr. WINEGARDEN. No. When you look at all the Iowa domestic carriers including Blue Cross/Blue Shield as a domestic carrier.

Mr. DINGELL. They wanted to be safe from regulation if they were returning 55 percent?

Mr. WINEGARDEN. Correct.

Mr. DINGELL. That is interesting. What were they in fact returning at that time? What was their loss ratio?

Mr. WINEGARDEN. I am afraid that is a number I can't pull off the top of my head.

Mr. DINGELL. You can't tell us about it?

Mr. WINEGARDEN. My guess is that we have a requirement in the Iowa market that—I think the minimum lifetime loss ratio that is permitted on an individual insurance policy form is 60 percent.

Mr. DINGELL. The minimum is 60 percent?

Mr. WINEGARDEN. Sixty percent.

Mr. DINGELL. Does Golden Rule make that?

Mr. WINEGARDEN. You are required to do so over time. Focusing on loss ratios isn't a very effectively regulatory tool in any case because loss ratio is really a function of premium. You can simply increase the premium to meet that loss ratio if need be, so playing with a premium can get you the loss ratio that you want. It is only a percentage of premium. It is not our focus on regulation.

Frankly, we think that the best protection for consumers is if they look at the bottom line, what does the policy cost them, what is it compared to the rest of the market opportunities, and we think by having a vibrant competitive market consumers are better protected. We do spend more regulatory time in the individual market than in the large group market or the small group market precisely because there aren't that many writers and it is not very competitive.

Mr. DINGELL. Let me ask one more question, and I would appreciate it if you would elaborate on this. The minimum loss ratio which is touted by Golden Rule as a device to keep premiums down is basically a promise that the company will escape regulation if they pay back a certain minimum percentage of the money that is collected in insurance premiums to the policyholders for claims filed; is that right?

Mr. WINEGARDEN. Yes, Mr. Chairman.

Mr. DINGELL. Can you manipulate that minimum loss ratio by any kind of accounting devices or anything of that sort?

Mr. WINEGARDEN. That was certainly one of our fears in looking at the proposal.

Mr. DINGELL. Why was it one of your fears?

Mr. WINEGARDEN. Reserves for claims made or expected claims shows up on the loss side of the equation.

Mr. DINGELL. In other words, you are talking about it is actually long-tailed matters that might at some future time become a problem?

Mr. WINEGARDEN. And manipulation of reserves is one concern. Additionally, we had concerns with regard to the actual allocation of administrative costs in claims administration to make sure they were counted on the administrative cost side of the equation and not counted against the loss side or the claims payment to consumers. Remember, in the procedural agreement with Golden Rule these were among the questions that we asked, proved to us that these concerns are addressed.

They were not answered. If there is an answer for them, they have not been provided to us yet and it is not a current issue in

Iowa, although I understand that it has been a matter of discussion before Congress.

Mr. DINGELL. You said that the average amount paid out by insurance companies——

Mr. WINEGARDEN. In the individual market. The loss ratios are much higher in administrative costs, but lower in the large group or the small group market.

Mr. DINGELL. And you said if you exclude the Blues, it ran about 67 percent?

Mr. WINEGARDEN. Correct.

Mr. DINGELL. Golden Rule wanted to get it to the point where it was 55 percent, is that right?

Mr. WINEGARDEN. Correct.

Mr. DINGELL. Am I fair in assuming that the companies that were engaged in the sale of insurance on a payout of 79.89 percent or 67 percent except for the nonprofits were making an adequate profit? Isn't that one of the requirements that you have in Iowa law; that there must be a fair return to the insurance companies?

Mr. WINEGARDEN. Absolutely. The business of insurance is really a promise to pay on a future occasion and the promise of an insolvent company is not worth much. So we are first and foremost concerned with solvency and an adequate return and profit is important to that.

Mr. DINGELL. So profit is both a constitutional requirement and a matter related to the solvency of the company; is that right?

Mr. WINEGARDEN. Absolutely.

Mr. DINGELL. Let's exclude the Blues, because they are nonprofit—what would be the level of profit in the average company running around 67 percent?

Mr. WINEGARDEN. In the insurance industry as a whole, the rate of profit on capital invested is actually relatively low, approximately 3 percent, and that is substantially lower rate of profit on capital than the less risky industrial sector in the United States which over the last 20 years has averaged a 7 to 8 percent return. In the individual market there are companies that have much higher profit rates than the industry average for insurance as a whole of 3 percent.

Mr. DINGELL. We must assume that at 55 percent they would have done quite nicely.

Mr. WINEGARDEN. It is my understanding that Golden Rule are doing quite nicely, as are several other writers in the individual market.

Mr. DINGELL. The Chair notes my time has expired.

Does the gentleman from Texas have questions?

Mr. BARTON. I yield the Chairman such time as he may consume.

Mr. DINGELL. Mr. Coffman, as Ms. Hurwit noted earlier, Golden Rule got an A-plus rating from A.M. Best specifically because of its strong profitability and strong market niche in the health insurance field. A.M. Best went on to suggest that the company's profitability was due to, "implementation of rate increases, raising of deductibles and marketing limitations on certain group health coverage."

That says that they had some remarkably fine business practices; didn't it?

Mr. COFFMAN. Certainly it does, Mr. Chairman.

Mr. DINGELL. And it says that they really made their profits through the device of implementation of rate increases, raising of deductible and marketing limitations on certain group health coverage; is that right?

Mr. COFFMAN. Yes. If we go back to the comments of the First Deputy from Iowa, they are playing by the rules and clearly they have been able to influence what the rules are and been able to devise a pretty good profit by doing so.

Mr. DINGELL. Mr. Coffman, you observed in your testimony that health insurers are not eager for change. I think that is a matter on which we can all agree.

You indicate that Golden Rule's staunch opposition to your reforms and those in other States suggest that they will not change unless forced to do so. Under the circumstances, it is a little difficult to agree with anyone who might say that Golden Rule's practices constitute those of an exemplary corporate citizens. What would you say about that?

Mr. COFFMAN. Mr. Chairman, I think that it has been said earlier today that one carrier cannot step out on their own and do affirmative things because they would get hit with adverse selection. There has to be a level playing field. They have fought against changes in the system in reference to their market that would allow people of higher risk to be taken care of. I know they do a lot of great things outside of the insurance company, but I think in terms of the insurance industry and the State of Colorado they have not been a good corporate citizen.

Mr. DINGELL. Does the gentleman from Texas have any questions?

Mr. BARTON. I just have one, really more of a political question to the two State representatives. Are either of you aware if Golden Rule is planning any punitive effort to replace you because of your exercise of your rights as a representative in your various legislators? In other words, are they coming after you because you didn't agree with them?

Mr. COFFMAN. Congressman Barton, I am not aware of any efforts against me nor any efforts of those members of the Colorado General Assembly who supported my reform proposal.

Mr. SCORSONE. No, sir. As of this time I am not aware of any. If I could possibly answer the question about the risk pool briefly.

Mr. BARTON. At the Chairman's discretion. I would be happy to have you answer that, also.

Mr. SCORSONE. I do know that Golden Rule and other companies have advocated risk pool, but the way they and others have suggested that we have a risk pool for the high-risk people is that then the State pick up the tab for paying for the high-risk people. I think what happens then in terms of a practical matter in about 20-odd States that have risk pools is that you have a lot of dumping and private insurance companies just dump the high-risk people in these risk pools and let the government pay for this. It seems to me that if you are going to have a risk pool, the only equitable way to do it is to take the cost of covering those individuals

and distribute it according to market share of the companies that operate in that area.

But let me also suggest that the risk pool is probably not a good idea because it seems to me that the incentive ought to be for the company that has a high risk individual to manage that care efficiently and effectively. If that company has to retain that individual, the incentive is there for the company to manage that individual well and efficiently. A risk pool I think is passing the buck and ultimately is a disincentive I think to the market.

Mr. DINGELL. Gentlemen, you have been very helpful to the committee. The Chair wants to thank you for your kindness to us.

The Chair notes that you have added certain additional information to your statements and without objection that will be inserted in the record, the Appendices that you have submitted to us.

The Chair is going to keep the record open in this matter for an appropriate period of time for purposes of receiving such additional comments as you might want to make or other information that the committee might request of you.

The Chair thanks you all very much for being here. You have come a long way and you have been of great assistance to the committee.

The Chair advises that it is 12:20. There will be some votes on the Floor shortly. I think the Chair is going to have to recess.

The Chair would ask Mr. Whelan—Mr. Whelan, does coming back here at 2 o'clock sound all right to you?

Mr. WHELAN. Yes.

Mr. DINGELL. The committee will stand in recess until 2 o'clock.

[Brief recess.]

Mr. DINGELL. The subcommittee will come to order.

Our next witness is Mr. John M. Whelan, Chief Executive Officer Golden Rule Insurance Company, Golden Rule Building, 712 11th Street, Lawrenceville, Illinois.

Mr. Whelan, you have heard the Chair qualify the witnesses as they have appeared here. As you understand it, the requirements are that witnesses testify under oath.

Do you have any objection to testifying under oath?

The Chair advises you that given that, you are entitled to be advised by counsel during your appearance here.

Do you desire to be advised by counsel during your appearance here?

Mr. WHELAN. Yes.

Mr. DINGELL. Is that Mr. Altman?

Mr. LESHER. I am with Mr. Altman, as well, as counsel.

Mr. DINGELL. Mr. Altman's counsel?

Mr. ALTMAN. I could probably use it, Mr. Chairman, but no, Mr. Whelan's counsel.

Mr. DINGELL. That is entirely appropriate.

You will note that copies of the Rules of the House, the Subcommittee and the Committee are at the witness table to advise you of your rights as you appear before us.

[Witness sworn.]

Mr. DINGELL. You may consider yourself under oath.

The Chair will be happy now to recognize you for such statement as you choose to give.

TESTIMONY OF JOHN M. WHELAN, CHIEF EXECUTIVE OFFICER, GOLDEN RULE INSURANCE COMPANY

Mr. WHELAN. Thank you, Mr. Chairman and members of the subcommittee.

My name is John M. Whelan. I am the President and Chief Executive Officer of Golden Rule Insurance Company. Seated with me are Robert Altman and Grif Lesher, Washington, DC, counsel to Golden Rule.

I am pleased to have this opportunity to appear here today and will attempt to explain to the subcommittee how Golden Rule operates. In the process I will address some erroneous impressions about the company that previous witnesses have placed in the records of these proceedings.

I have submitted a written statement which contains input from various people at the company and is intended to be responsive to the subcommittee concerns.

Mr. DINGELL. Without objection, that written statement will appear in the record.

Mr. WHELAN. As shall be made clear, Golden Rule's insurance business differs substantially from the business of the major health insurance companies in this country. Golden Rule's strategic focus involves the sale of health insurance to individuals and small to mid-sized groups. Golden Rule has been successful in offering such coverage because the Company: offers excellent health insurance benefits; charges moderate prices for its coverage; uses sound underwriting concepts to evaluate and manage risk; complies with all Federal and State laws and regulations; and works to protect the interests of our policyholders.

Golden Rule's individual insureds have largely been ignored by the major health insurance companies. Our customers include persons who are between jobs, unemployed, and self-employed; students; early retirees; widows; and others in transitional phases of their lives. These Americans are able to get needed health insurance from Golden Rule at an affordable price.

Unlike many health insurance carriers, Golden Rule does not use economic underwriting to deny coverage to less affluent Americans. Not surprisingly, a high percentage of our customers are people of modest means. Our lower premium costs enable waitresses, taxi drivers, farmers, and unskilled laborers to secure needed health insurance protection with Golden Rule. In fact, 20 percent of our customers who purchase our individual health insurance policies have incomes of less than $15,000. Nearly 45 percent are purchased by customers who have household incomes of less than $25,000.

While health care reforms are debated, Golden Rule today is making health insurance benefits available to hundreds of thousands of lower income Americans.

During the course of these proceedings, unfair criticisms have been leveled at Golden Role concerning our business practices. Some complaints flow from erroneous factual information about the company. Certain charges reflect a fundamental misunderstanding of the business of insurance. And some simply are unfortunate broadside attacks.

This is not to say that Golden Rule never makes a mistake. We are a large company and we do and we fix those. But we consider the criticisms voiced during these hearings to be unfair.

Today we shall seek to respond with facts to demonstrate to the satisfaction of the Subcommittee that these allegations are without merit.

Critics of Golden Rule have, essentially, wrongly suggested that the company insures only young people who are healthy; cherry-picks policyholders to weed out unhealthy people; enjoys unusually favorable loss ratios; refuses proper claims from our insureds, and improperly lobbies State legislatures.

These allegations are demonstrably false. I shall address each in turn.

First, targeting the young. Golden Rule does not target its health insurance policies to young customers. In fact, over 50 percent of our insureds are between the ages of 35 and 64; 13.9 percent of our individual policyholders are between the ages of 55 and 64 which closely reflects the 13.5 percent that group constitutes as a percentage of the United States population. While we certainly attract a large number of young policyholders with our low premiums, the company does not favor any particular age group as a marketing focus.

Second, cherry-picking. Equally incorrect is the suggestion that the company "cherry-picks" insureds to weed out unhealthy individuals from its pool of policyholders. Cherry-picking refers to a practice of rewriting insurance for people in a risk pool who are healthy.

At Golden Rule, once an insured pool is created, the company makes every effort to preserve that pool to spread risk of loss over a large group. Golden Rule does not try to segregate healthy policyholders in a new pool. Indeed, Golden Rule will not allow its insureds to rewrite coverage from an older policy to a similar newer form. If one of our existing healthy policyholders drops coverage with us, we do not permit that individual to purchase a new policy from Golden Rule for 1 year to avoid "cherry-picking" initiated by the insureds themselves.

Third, "bait-and-switch" claims. Before Golden Rule offers individual health insurance for sale, a submission is made to the State which includes the projected loss experience for the product. Following State approval, Golden Rule then offers that insurance coverage at the approved rate.

If "low-ball" premiums were charged initially to attract customers, it follows that the company's original loss ratios would be too high-and not consistent with the loss projections given the State. Thereafter, the company's loss ratios would improve to reflect the financial advantage of higher rates, that is, the "switch." Yet, our loss ratios are consistent with industry norms—that is, starting lower and climbing over time. Such loss ratio trends discredit claims of "bait-and switch" practices.

To be clear, Golden Rule has no unfettered ability to increase premiums. Rate hikes can only be justified by the loss experience of a pool. Moreover, rate hikes tend to drive away healthy insureds. The loss of those customers is highly damaging and to be avoided,

as it eliminates our ability to spread risk. In short, we do not "bait-and-switch" at Golden Rule.

Fourth, wrongful denial of claims. We are aware of concerns—based on anecdotal evidence-regarding Golden Rule's practices in processing claims. We submit the facts show Golden Rule handles insureds' claims both fairly and efficiently. On average, Golden Rule processes some 6,000 or 7,000 claims every day. Our records show that we pay 90 percent of valid claims within 5 working days or less from the time proof of loss is received; 98 percent of these claims are paid within 10 working days or less. We currently pay out, on average, $1.5 million a day on claims. This hardly suggests we are a foot-dragging firm, reluctant to honor our obligations to policyholders. Rather, we are a model for timely processing.

As with virtually all health insurance contracts, Golden Rule's policies contain a pre-existing condition limitation for ailments that predate coverage. Unlike many carriers, Golden Rule only rejects claims on pre-existing conditions that are submitted during the first year of coverage.

The use of pre-existing condition limitations to deny coverage to policyholders is limited. Mr. Chairman, you and your constituents will be interested to learn that in Michigan, for example, company records indicate that during 1989–1991, pre existing conditions were the basis for denials in only one-half of 1 percent of the individual health claims received.

Potential controversy may arise when an applicant for health insurance fails, truthfully and accurately, to report serious medical conditions to Golden Rule. In these instances, the company may be compelled to file suit to void the policy when it discovers material misrepresentations were made.

But the factual record refutes any suggestion of questionable litigation practices, and shows how infrequently lawsuits over claims occur. The number of declaratory judgments filed by Golden Rule during 1990–1993 ranged from a high of 113 in 1990 to a low of 28 cases in 1993. These modest numbers stand in dramatic contrast to the thousands of claims we process every day.

Fifth, loss ratios. Questions have also been raised concerning our loss ratios. We believe the loss ratios for individual health insurance pools at Golden Rule are completely consistent with industry norms. For example, for the period 1991–92, Golden Rule's individual health coverage known as "Inflation Guard I,"which in 1991 represented over 75 percent of all premiums paid to the company generated loss ratios of 70 percent.

And, Golden Rule uses only earned premiums and incurred claims to compute loss ratios. Our significant general and administrative expenses are not included in our loss ratio calculations.

Sixth, State insurance. As Golden Rule operates in a highly regulated industry, it is to be expected that we may disagree-sometimes sharply-with the policies and actions of some State regulators. In recognition of our concurrent responsibility to policyholders, Golden Rule does not hesitate to advocate our views forcefully to regulators when action is being taken which is damaging to our policyholders.

On occasion, disputes with insurance commissioners have led to litigation. This generally involves instances where we believe a regulator is acting arbitrarily or outside the scope of his statutory au-

thority. We have submitted information to the Subcommittee on certain of these cases.

Seventh, State lobbying efforts. As part of our regular business activities, Golden Rule monitors legislative initiatives that may affect our industry. When such legislation is being developed, Golden Rule may become actively involved in lobbying efforts.

At times we advocate our positions on legislation strongly and publicly-even dramatically. And, at times, our pointed opposition to legislative proposals does not please the sponsor of a particular bill. We consider our involvement in the legislative process to be not merely our right, but part of our obligation to our policyholders. At all times we are careful to comply with the lobbying laws and regulations of the state.

Concern over escalating health care costs is at the heart of the legislative debates over health care now taking place in Congress. We are proud that Golden Rule provides health insurance coverage at reasonable prices so it becomes affordable for less affluent Americans.

Golden Rule has supported reforms which, we believe, would be of value in containing future costs. We have advocated loss ratio guarantees, portability of insurance, the adoption of medical savings accounts, and tax fairness reforms which would help restrain health care costs. We hope they receive careful consideration by the Congress.

Golden Rule appreciates the opportunity afforded us by the Subcommittee to appear here today. Mr. Chairman, we shall be pleased to answer any questions you or members of the subcommittee have.

[The prepared statement of Mr. Whelan follows:]

Statement
of
John M. Whelan
President and
Chief Executive Officer
Golden Rule Insurance Company

Mr. Chairman and Members of the Subcommittee:

My name is John M. Whelan, and I am President and Chief Executive Officer of Golden Rule Insurance Company. I am pleased to have this opportunity to appear here today and would hope to assist the Subcommittee in its investigation of the practices of the health care insurance industry. In the process, I will attempt to explain how Golden Rule operates and correct some erroneous impressions and factual errors about the Company that previous witnesses have placed in the record of these proceedings.

Golden Rule is a life and health insurance company founded in Illinois in 1940. In the early years, Golden Rule offered only life insurance. The Company expanded its operations in 1946 when it added accident and health insurance to its portfolio. Today, Golden Rule is known as a leader in the individual health insurance market. Since its incorporation, Golden Rule has strived to provide efficient, dependable service and high-quality products for our policyholders. The Company has always been committed to providing coverage to its insureds at an affordable cost, and processing their claims quickly and fairly.

As shall be made clear, Golden Rule's insurance business differs substantially from the business of the major health insurance companies in this country. As a result, our business practices and philosophies often diverge from those large corporate carriers. We are not a member of the Health Insurance Association of America (HIAA) and have not been involved in the Association's activities in the health care reform debate in Congress. Indeed, we support certain legislative initiatives opposed by other large health insurance carriers.

Golden Rule's strategic focus involves the sale of health insurance policies to individuals and small to mid-sized groups. We thus serve a market that has largely been abandoned by the

large health insurance firms which are devoted, almost exclusively, to the more lucrative, less risky business of selling large group health insurance plans.

Golden Rule has been successful in offering insurance coverage to individuals and smaller groups because the Company:

- offers excellent health insurance benefits
- charges moderate prices for its coverage
- uses sound underwriting concepts to evaluate and properly manage risk and loss experience
- processes claims quickly and fairly
- complies with all federal and state laws and regulations that govern our business, and
- strives always to protect the interests of our policyholders.

Golden Rule's individual insureds have largely been ignored by the marketing practices of the large health insurance companies. Our customers include persons who are between jobs, unemployed, self-employed, or employed by small businesses; students and recent college graduates; dependents reaching their majority; the recently divorced; early retirees; and others in transitional phases of their lives. We find that a significant number of recently widowed women (who lose their husbands' health insurance coverage) are counted among our policyholders. These Americans are able to get needed health insurance from Golden Rule at an affordable price.

Unlike many health insurance carriers, Golden Rule does not use economic underwriting principles to deny coverage to less affluent Americans. Not surprisingly, a high percentage of our customers are people of modest means. Our lower premium costs enable waitresses, taxi drivers, farmers, and unskilled laborers to secure needed health insurance protection with Golden Rule. In fact, 20% of our customers who purchase our individual health insurance policies have incomes of less than $15,000. Nearly 45% of our individual policies are purchased by customers who have household incomes of less than $25,000, and over two-thirds of our customers have household incomes below $35,000.

Of course, every dollar is important to these policyholders. Unlike those who receive health insurance tax-free through their employer, our policyholders must purchase their coverage with after-tax dollars.

Congress struggles today to find a means for extending health insurance benefits to all Americans, particularly lower income people. Golden Rule supports the concept of universal access. While health care reforms are debated, however, Golden Rule today is making health insurance benefits available to hundreds of thousands of lower income Americans.

Misconceptions About Golden Rule

During the course of these proceedings, unfair criticisms have been leveled at Golden Rule concerning the business practices of the Company in dealing with its insureds. Concern is also expressed about Golden Rule's dealings with state regulators and state legislators. Many of the complaints that have been voiced flow from erroneous factual information about the Company. Certain of the charges reflect a fundamental misunderstanding of the business of insurance. And some simply are unfortunate broadside attacks which lack any factual foundation.

During the course of our testimony, we shall seek with factual evidence to establish to the satisfaction of the Subcommittee that these allegations are totally without merit. We are confident that an objective observer of these proceedings will conclude that Golden Rule is an ethical, well-managed health insurance provider, a company that strives always to protect its policyholders' best interests.

Business of Insurance

We believe it might be helpful to offer some brief comments about the business of insurance to place Golden Rule's management practices in proper context. It needs to be understood that insurance involves the spreading of risk relating to a future uncertain occurrence across a large group of people. Insureds are required to pay a premium that reflects the loss experience

that is expected to occur to the group, though the individuals in that group who will suffer a loss cannot initially be identified.

It follows that it is the fundamental responsibility of an insurance company to evaluate and manage the risk of loss expected to occur within the pool of insured policyholders. Critical to this risk management function is the application of sound underwriting concepts to those who desire insurance coverage by the Company. In this way, a company remains financially sound, able to meet its financial obligations to policyholders as they come due.

Golden Rule applies well-recognized, medical underwriting principles to evaluate risk of loss at the time applications for health insurance are filed. When an applicant for health insurance has already suffered the condition for which coverage is sought, Golden Rule will - and must - decline to issue a policy. To do otherwise is not the business of insurance, i.e., financial protection against an <u>uncertain</u> future contingency.

Fire insurance is not provided after the house catches fire, nor is auto theft insurance provided after the car is stolen. To provide health coverage to people for a medical condition which has already occurred may be charitable; it is not the business of insurance.

While adhering to sound underwriting principles,* Golden Rule issued insurance coverage during 1990-1993 to approximately 90% of all applicants. Of course, applications may be rejected for a number of reasons unrelated to the health of the applicant. In some instances, when an applicant discloses an existing medical problem on his or her application, insurance coverage from Golden Rule will be approved, excluding that particular

---

*Contrary to the position of other health insurance carriers, Golden Rule opposes both genetic screening and HIV blood tests for applicants who desire individual health insurance protection.

medical problem. We are pleased that Golden Rule now provides health insurance protection to approximately 800,000 Americans.

Unwarranted Criticisms

Critics of Golden Rule have, essentially, wrongly suggested that the Company's practices and objectives are to -

- insure only young people (who are healthy, probably do not need coverage, and will not file many claims);
- "cherry-pick" policyholders to weed out unhealthy people likely to file claims;
- charge low introductory premiums to customers, but quickly increase premiums repeatedly (i.e., "bait-and-switch");
- refuse to pay claims owing to policyholders who experience a loss by use of strong-arm litigation tactics and invocation of pre-existing condition clauses;
- generate highly favorable loss ratios (compared to industry standards) which produce egregiously large profits for the Company;
- impede proper state regulatory controls by resorting to meritless litigation;
- rely on tactics of intimidation and the spread of misinformation to defeat health care reform in state legislatures; and
- add to escalating health care costs in this country.

All of these allegations are demonstrably false. We shall address each of these below.

"Targeting Only The Young"

Golden Rule does not target its health insurance policies to young customers. Nor does it apply demographic underwriting standards to applicants seeking insurance. It is, in fact, of no particular import to Golden Rule whether its insureds are young, middle-aged, or older.* Our records readily establish that

*Although Golden Rule does not target younger market segments, the Company does provide special financial incentives for customers with families. Unlike many insurance companies, Golden Rule does not charge its policyholders for each additional child covered by the Company's health insurance after the first child is added to a policy. Those children receive the health insurance benefits for free from Golden Rule, while common industry practice is to charge an additional premium for each child added to a policy.

Golden Rule insures all age groups.

The records of Golden Rule reveal that over 50% of our insureds are between the ages of 35 and 64. Indeed, 13.9% of the individual policyholders insured by us are between the ages of 55 and 64 which closely reflects the 13.5% that that group constitutes as a percentage of the United States population.

When we are addressing market segment strategies, it is important to understand that Golden Rule's health insurance policies are bought, not sold. By this we mean that health insurance policies are generally purchased when an individual perceives the need for coverage and seeks out an insurance provider.

The Company does not seek to identify prospective customers and persuade them to buy. Rather, producers - whether they be agents or brokers - may offer individuals who contact them health insurance policies from various companies, one of which is Golden Rule. And we do not instruct producers to target younger applicants for Golden Rule's health insurance policies.

"Cherry-picking"

Related to the false allegation that Golden Rule targets young and healthy individuals is the charge that the Company "cherry-picks" insureds to weed out unhealthy individuals from its pool of policyholders. Again, this is untrue. Golden Rule regards such practices as improper and unwise, and has adopted policies to avoid even unintentional "cherry-picking".

To avoid confusion it will be necessary to define "cherry-picking", as that term has been used by the insurance industry. Traditionally, the term refers to the practice of rewriting insurance for people in a risk pool who are healthy. This may be accomplished when a carrier terminates a broad group of insureds and then selects the healthy risks to whom it offers replacement coverage with the company. Alternatively, a company could permit healthy policyholders to move their coverage to a new plan with the carrier, leaving a sicker pool of insureds behind.

Once a pool of Golden Rule policyholders is created, the Company makes every effort to preserve that pool. Golden Rule does not seek to segregate healthy policyholders in a new pool while sharply increasing premiums for (and perhaps terminating) those remaining in the original group. Such "cherry-picking" causes a phenomenon in the insurance industry called the "death spiral", i.e., the destruction of the actuarial integrity of the insured pool. Notably, Golden Rule has never experienced this result in any risk pools of its insureds.

Golden Rule has always endeavored to preserve each pool of insureds (which combines the healthy and unhealthy policyholders) to spread risk of loss over a large group. So careful is Golden Rule to avoid "cherry-picking" that on occasion it does not immediately charge policyholders significantly higher premiums (approved by the state) that might cause healthy insureds to drop their coverage. Such approved rate increases may be phased in over time. By thus keeping insurance affordable, Golden Rule is able to maintain the risk pool, and avoid "death spirals."

Indeed, unlike some carriers, Golden Rule will not allow its insureds to rewrite coverage from an older policy to a newer form. If one of our existing healthy policyholders drops his or her coverage with us, we do not permit that individual to purchase a new policy from Golden Rule for one year to avoid "cherry-picking" initiated by the insureds themselves.

It would appear axiomatic that Golden Rule would enjoy unusually favorable loss ratios if it were to engage in "cherry-picking" young healthy individuals for its policyholders. Yet no such unusual financial results are found. As will be seen below, Golden Rule's loss ratios for its health insurance pools are consistent with the norms for this industry.

"Bait-And-Switch"

One of the more sensational concerns raised about Golden Rule's practices is the suggestion that the Company seeks to attract new policyholders with artificially low rates, and once hooked, repeatedly implements large rate increases. A brief

review of the facts will demonstrate that this charge, loosely referred to as "bait-and-switch" tactics, is plainly untrue.

Before Golden Rule offers an individual health insurance product for sale, a submission is made to the state insurance commissioner. That filing includes not only the proposed insurance policy and benefits, but also the projected loss experience over the duration of the contract - a projection supported by actuarial memoranda. Following approval of its submission, Golden Rule is able to offer that insurance coverage to prospective policyholders at the approved premium rate.

Of course, if "low-ball" premiums were charged initially to attract customers, the Company's loss ratios on these newer customers would necessarily be too high - and not consistent with loss projections submitted to the state. That has not happened.

Further, in any "bait-and-switch" insurance program, the Company's loss ratios for established customers would then improve, not worsen, to reflect the financial advantage to the Company from higher rates, i.e., the "switch." Yet, the fact is that our loss ratios are consistent with industry norms, i.e., loss ratios start lower and rapidly climb over time. Such loss ratio trends conclusively disprove the use of "bait-and-switch" strategies.

It is worth observing that Golden Rule has no unfettered ability to increase premiums sharply to policyholders, and significant disincentives discourage that practice. Rate hikes can only be justified by the loss experience of a pool. Higher premium rates cannot be imposed on policyholders without this loss justification. Moreover, rate hikes tend to drive away the healthy insureds who can buy less expensive coverage elsewhere. Loss of these customers, and the attendant ability to spread risk, can produce the "death spiral" phenomenon described above.

We feel constrained to note that "bait-and-switch" strategies, if attempted by an insurance provider, could probably not be successfully implemented. The effort to charge higher

rates would cause healthy insureds to drop their coverage, and the increased rates would not generate enough money for the insurer to cover claims in the remaining risk pool.

Additional confirmation of Golden Rule's opposition to business practices like "bait-and-switch" is made clear by our support of loss ratio guarantees. Loss ratio guarantees permit an insurance company to adopt rate hikes without formal prior approval, provided the company agrees to refund premiums paid by policyholders if the firm's loss experience is better than predicted. This program eliminates any financial incentive for a health insurance carrier to use "bait-and-switch" strategies, as any excess profit gained would have to be refunded. Golden Rule has been instrumental in the adoption of loss ratio guarantees in the states and would favor the implementation of this concept nationwide.

Wrongful Denial of Claims

In the hearing of this Subcommittee on June 29, 1994, testimony was presented that suggests Golden Rule avoids making payments due policyholders on their claims, presumably to enrich the Company unjustly. The actual facts regarding the Company's claims processing practices put the lie to this charge.

Golden Rule is in the business of honoring the legitimate claims of policyholders, not contesting them. We endeavor to meet our obligations to our insureds fairly and expeditiously. We recognize that claims processing involves transactions that are of great importance - and often a matter of some urgency - to our customers.

Rather than impede, delay, or deny payments due our policy-holders, Golden Rule is an industry leader in timely claims processing. On average, Golden Rule now processes some 7,500 claims per day. Our records show that we pay 90% of valid claims within five working days or less from the time proof of loss is received. 98% of these claims are paid within ten working days or less.

We believe our claims processing is a model for the industry. We challenge any of the major health insurance providers to beat our record.

Our claims payments involve large amounts of money. We currently pay out, on average, $1,500,000 a day, every work day. This hardly suggests we are a foot-dragging firm, reluctant to honor our obligations to policyholders.

We are, it should be said, under no legal obligation to process claims - and make payments - so quickly. In fact, in states like Texas (which enacted a fair claims practices statute with specific deadlines), it is a statutory objective for carriers to make payments on claims within 30 days. Most other states have no such requirements.

Consider the economic value to Golden Rule of the "float" on millions of dollars if we were simply to delay payments to policyholders for 30 days which we have the option to do. Such delays would be worth millions in extra income to the Company each year. But that is not the way we do business.

We are proud of our record in claims processing.

Medical Exclusions and Pre-existing Conditions

Despite our claims processing record, critics of Golden Rule have suggested that the Company unfairly invokes exclusionary clauses in its insurance contracts to deny benefits to policyholders who are rightfully entitled to payment. That is wholly untrue. As will be seen, Golden Rule's policies are not only consistent with state law and industry practice, they are unusually favorable to policyholders.

When an applicant for insurance truthfully completes the application form and discloses his or her medical history, Golden Rule is able to evaluate the risk. When a medical problem already exists, we issue coverage with a specific exclusion for the ailment that the applicant has disclosed. Golden Rule and the customer thus understand from the outset what is covered by the policy and what is excluded.

As with virtually all health insurance contracts, Golden Rule's policies also contain a pre-existing condition limitation which permits the Company to reject claims for ailments that pre-date coverage. Golden Rule's provision is more favorable to the insured than most state laws allow. Most states grant an insurance company the right to deny coverage to claimants when there were medical conditions that existed five years before the policy was issued. Under Golden Rule's policies, coverage is only denied when medical advice or treatment for the pre-existing condition was received in the two years prior to the application, or when symptoms of that condition occurred one year prior to issuance of the application.

Further, Golden Rule only rejects claims on pre-existing conditions that are submitted during the first year of coverage. Thus, even when an applicant fails to disclose an existing medical problem, Golden Rule will not generally deny coverage on such claims submitted more than one year later.

The use of pre-existing condition limitations to deny coverage to policyholders is limited. In Michigan, for example, Company records indicate that during 1989-1991, pre-existing conditions were the basis for denial in only 0.5% of the individual health insurance claims received.

Potential controversy may arise when an applicant for health insurance fails, truthfully and accurately, to report serious medical conditions to Golden Rule. In these instances, the newly insured individual may later file a claim for a medical problem that almost certainly was known to the person when the policy was purchased - but which the applicant failed to disclose to Golden Rule. When such material misrepresentations by an applicant are discovered, Golden Rule will attempt to return the parties to the position they would have been in had the true facts been disclosed in the application. If it becomes necessary, Golden Rule will void a policy considered to have been wrongfully obtained, and the customer's premiums will be refunded. By law, Golden Rule has a two-year "contestable period" to void coverage

due to material misstatements on the application. This may necessitate our filing a declaratory judgment within the "contestable period" to rescind the contract. (There are rare exceptions to the time limitation for cases involving serious, intentional efforts by a customer to defraud Golden Rule.)

Claims Litigation

Relying on anecdotal evidence, reference has also been made to litigation practices of Golden Rule, claiming that often we sue to deprive policyholders of claims dollars due them. It is true that the Company has filed suits for declaratory judgment when it discovers a policyholder has made material misrepresentation on an application. Such misrepresentations make risk evaluation impossible, and the Company, to preserve the premium dollars that must be paid on valid claims, will contest invalid ones.

But the factual record refutes any suggestion of questionable litigation practices, and shows how infrequently lawsuits over claims occur. The number of declaratory judgments filed by Golden Rule during 1990-1993 ranged from a high of 113 in 1990 to a low of 28 cases in 1993.* These numbers stand in dramatic contrast to the 7,500 claims we process every day.

In this vein, much has been made of the fact that some cases brought by Golden Rule were filed in Lawrenceville, Illinois, the home office of the Company. Various reasons justify our selection of Lawrenceville as the venue for these cases. Aside from the fact that it is our home office, Lawrenceville is the place where the particular insurance contracts in the litigation were underwritten and issued. The cost of litigation is considerably lower there and the less crowded dockets afford both the Company and the policyholder a quick resolution of the matter.

Yet, the number of lawsuits filed in Lawrenceville is not

*Some of the cases are filed to preserve our legal rights when the contestable period for a given policy is about to expire.

significant. 43 cases were filed in 1991. By 1992, only 8 cases were filed in Lawrenceville, and in 1993, there were only 6 cases. Regardless of venue, Golden Rule has been successful at trial in the overwhelming majority of cases where claims are challenged as invalid or fraudulent.

Nor is there any merit to the suggestion that Golden Rule somehow benefits financially in pursuing litigation to defeat claims of policyholders. It may well cost the Company more to litigate than to pay an invalid claim. This, however, is a matter of principle for us.

Loss Ratios

Many of the misconceptions about Golden Rule can be traced to erroneous information that has been introduced in the record regarding the loss ratios of Golden Rule. Properly understood, our loss ratio experience establishes that the Company is not engaged in business practices that are inimical to the best interests of its policyholders or the public. Nor are our loss ratios unusually low.

It must be recalled that Golden Rule is primarily directed to the offering of individual and smaller group health insurance. Unlike large group insurance, normal actuarial projections for individual health insurance make clear that loss ratios are expected to be lower in the first year when a pool of business is created; the ratios deteriorate rapidly within the next two years as people get sick or injured, and claims are filed. This loss trend is well known by insurance regulators, and is reflected in submissions filed by Golden Rule with the states.

Offsetting the temporary distortion of loss experience for the pool in the first year are the substantially larger overhead expenses incurred by an insurance company that provides health insurance coverage to individuals. Compared to group insurance providers, a company writing individual health insurance incurs much higher costs to acquire, underwrite, issue and service each insured. These Golden Rule insurance policies are purchased one

person at a time. Each application must be underwritten separately. Approved policies are forwarded to our insureds one at a time rather than in bulk, and all future communications, including premium billing, require individual handling. All of this requires more work and involves much greater costs per insured individual.

To be clear, Golden Rule uses only premiums received and claims paid to compute its loss ratios. Our significant general and administrative expenses are not included in our loss ratio calculations.

We believe the loss ratios for individual health insurance pools at Golden Rule are consistent with industry norms. For example, for the period 1991-1993, Golden Rule's individual health coverage known as "Inflation Guard I" - which in 1991 represented over 75% of all premiums paid to the Company - generated loss ratios of 70%. A smaller, newer group of insureds known as "Inflation Guard II" which was established in July 1990, similarly experienced renewal loss ratios in 1993 of nearly 70%.

It is emphasized that under the loss ratio guarantee programs of various states, there is no value to the Company in achieving a substantially better loss experience than the actuarial projections on which our rates are based. If that were to occur, the Company simply refunds to policyholders the excess monies received. Golden Rule's experience demonstrates it is highly skilled at projecting - with great accuracy - the loss experience that will occur.

In sum, Golden Rule's loss ratios in its portfolios are consistent with industry standards. Temporarily lower loss ratios in newer pools reflect actuarial projections, and they quickly mirror industry norms after a couple of years. We believe our loss ratio record disproves charges that Golden Rule earns abnormally large profits by engaging in the questionable business practices that have been discussed.

Relationships With State Insurance Regulators

We are aware that the Subcommittee has heard testimony from

a few insurance commissioners and is interested in Golden Rule's dealings with state regulators. Golden Rule operates in a highly regulated industry and follows a policy of working closely with insurance commissioners in a responsible and professional manner. Golden Rule's management insists on strict compliance with the laws and regulations of the jurisdictions where we do business.

It is, of course, to be expected that as a regulated company, we may disagree - sometimes sharply - with the policies and actions of some state regulators. In recognition of our concurrent responsibility to policyholders, Golden Rule does not hesitate to advocate our views forcefully to regulators when action is being taken (or a failure to act occurs) which we believe is damaging to the interests of our policyholders and Golden Rule.

On occasion, disputes with insurance commissioners have led to litigation where the controversy can be resolved in a more impartial forum. This generally involves instances where we believe a regulator is acting arbitrarily or outside the scope of his statutory authority.

We are advised that the Subcommittee is interested in cases filed by Golden Rule where a state regulator was sued personally, as distinct from his official capacity. There have been two such instances when that occurred and the background of those cases is as follows:

1. Suit was brought by Golden Rule in North Carolina against the insurance commissioner, James E. Long, in 1989. The matter involved rate increases sought by Golden Rule which the commissioner advised he would only approve subject to severe restrictions.

Golden Rule filed suit against Mr. Long contending that the commissioner lacked statutory authority to impose these conditions on justified rate hikes, and seeking damages for loss of premiums. The suit named the insurance commissioner in his personal <u>and</u> official capacity. I am advised that this was done

to adhere to the dictates of North Carolina law. If, as we alleged, the commissioner was acting outside the scope of his statutory authority, he was deemed by state law to be acting in his personal capacity.

After initially prevailing in the dispute at the trial court level which found the restrictions on Golden Rule's rate increases to be unlawful, that decision was later overturned. Our claims for damages were denied.

2. Golden Rule has also sued the Florida State Insurance Commissioner, Tom Gallagher, in a dispute arising from rate increases. In that peculiar instance, Mr. Gallagher <u>sought to force Golden Rule to raise rates sharply on senior citizens</u> who had purchased Medicare supplement policies. (The rate increase demanded by the State was based on an ill-conceived five-year prefunding concept that contravened state law). Golden Rule refused to raise its rates and publicly opposed the Commissioner's policy. Mr. Gallagher, who was then engaged in a political campaign, ran paid political ads in which, among other things, he accused Golden Rule of being a "scam" and a "rip-off artist".

Under Florida law, Mr. Gallagher's damaging attack on Golden Rule was deemed personal conduct, not official action. Accordingly, Golden Rule filed suit against Mr. Gallagher personally for damages. The Florida court has repeatedly refused efforts by Mr. Gallagher to dismiss the suit which is now set for trial in December. Golden Rule is confident it will prevail.

As a footnote to this matter, Golden Rule later sought a rate revision on its largest block of business in Florida. That revision was denied and Golden Rule sued the insurance department (not Mr. Gallagher personally). The administrative law judge ruled that the Commissioner's action was arbitrary <u>and</u> discriminatory. The rate increase we sought, though long delayed, was finally approved.

<u>State Lobbying Efforts</u>

As health insurance is an industry that is heavily regulated

at the state level, Golden Rule monitors state legislative initiatives that may affect our industry. When such legislation is being developed, Golden Rule may become actively involved in lobbying efforts. In our view, this is more than our legal right. Our activities reflect our deep commitment to protect the interests of policyholders.

At times we advocate our positions on legislation strongly and publicly - even dramatically. We may alert our policyholders when we believe they will be adversely affected by proposed reforms. We believe it to be the American system to encourage participation in the legislative process, and we remain willing to defend our positions.

At times our pointed opposition to legislative proposals does not please the sponsor of a particular bill. We are aware that State Senator Jeanne Shaheen, from New Hampshire, appeared before the Subcommittee to complain about our aggressive lobbying of a bill she favored. Despite Senator Shaheen's purported acceptance of our right to oppose this legislation, she appears to be personally offended that we did so. Yet we find her testimony to be most curious:

•Complaining about our tactics, Senator Shaheen is unable to cite a single action by Golden Rule that violated any law or regulation of the State. There were none.

•Complaining about our alleged dissemination of misinformation, Senator Shaheen is unable to cite one fact or statement we made that was in error. There were none.

For the record, Senator Shaheen sponsored legislation in New Hampshire that involved: (1) pure community rating, i.e., a requirement that all policyholders in the State be charged the same premium regardless of age or circumstance, and (2) guaranteed issue, i.e., a requirement that every applicant for health insurance be granted coverage by any insurance company upon request, regardless of medical condition or circumstance. The bill would prohibit the use by insurance carriers of medical underwriting and exclusions for prior medical problems.

Golden Rule did - and does - disagree strongly with this legislation.* We believe it to be unsound, unworkable, and a disservice to the public. Among other things, we pointed out that this legislation would have the following consequences:

1. Force younger insureds (with lower health risks) to pay dramatically higher, onerous rates to subsidize older, generally more affluent insureds (with greater health risks);

2. Make insurance inaccessible for many younger insureds because it becomes unaffordable;

3. Encourage people to drop their coverage and then buy insurance only _after_ they become ill;

4. Eliminate personal responsibility for health care so that, for example, smokers and non-smokers are treated as equal risks;

5. Undercut efforts to extend health insurance coverage to more people by driving large numbers of people out of the system;

6. Cause substantially higher rates for insurance coverage.

In support of our position, we have pointed to the experience of New York State which had earlier enacted a bill that follows Senator Shaheen's legislative formula. Premium rates in New York have, as predicted, skyrocketed. For example, rates for 30 year-old males last year jumped 170% according to a July 24, 1994 article in the _New York Times_. It is now expected that most New Yorkers, even many older insureds who should benefit from community rating by getting lower rates, will find premium costs have risen well above the levels they were charged before community rating was adopted. This is due to the fact that in the first nine months of the program, more than 15% of individual policyholders dropped their coverage.

To date, we understand that more than 500,000 New Yorkers have given up their health insurance protection. Since those dropping out are predominately the young and healthy, rates are forced upward for all other policyholders. These facts are compelling, in our view.

---

*In response to objections of Golden Rule and others, Senator Shaheen amended her bill to drop pure community rating in favor of an improved, modified community rating system.

In response to our advocacy of such points in New Hampshire, Senator Shaheen - apparently lacking a factual rejoinder - resorted to ad hominem attacks, calling us "hucksters" who use "lies and half-truths" to earn "obscene profits". An attorney for the Company cautioned Senator Shaheen by letter, advising that her statements were false and defamatory. We viewed this as a measured response to her unfortunately personal attack.

Significantly, Senator Shaheen during her appearance before the Subcommittee, identified no alleged lie or half-truth expressed by Golden Rule to our knowledge. Nor did she support her untrue charge of obscene profiteering. Nor could she show we violated any lobbying law of the State.

We regret Senator Shaheen resorted to name-calling in response to our lobbying efforts, but we have let the matter drop.

Health Insurance Reform

Golden Rule wishes to make clear it does not oppose thoughtful health insurance reform efforts. We strongly support legislative concepts - some opposed by other companies in this industry - that will achieve the objectives many of us share, including the need for universal access to health insurance.

Golden Rule supports universal access, but recognizes that there exists a small percentage of the population with medical conditions that make them uninsurable. The solution, in our view, is not simply to issue those individuals an insurance policy as though they were healthy. It is, for this reason, that Golden Rule has opposed the concept of guarantee issue.* Golden Rule instead supports the concept of CHIPs (Community High-Risk Insurance Pools), paid for by all health insurance companies in a market - not taxpayers - which would enable all Americans to

---

*Guaranteed issue eliminates the need to carry insurance for an unknown catastrophic health expense. If one can buy insurance when illness strikes, it would make little financial sense for a healthy person to carry coverage. Restricted use of pre-existing condition provisions do not meaningfully affect this analysis.

receive insurance coverage. We would support federal legislation to achieve this result.

Among the other reforms Golden Rule supports are the following:

1. Portability - to guarantee coverage even when one changes jobs;

2. Modified community rating - to permit certain broad classifications such as age;

3. Loss Ratio Guarantees - to ensure that policyholders are charged fair premiums and receive the financial benefit if loss experience is better than was projected;

4. Medical Savings Accounts - to facilitate citizens gaining more control over their health care costs; and

5. Tax fairness - to permit deductibility of health insurance premiums by the waitress and the farmer as we do for large corporations.

Health Care Costs

Concern over escalating health care costs are at the heart of the legislative debates now taking place in Congress. While health care reform is not the Subcommittee's focus, we understand that increasing costs in the insurance industry is directly relevant to this investigation.

It is to be recognized that health insurance providers have limited ability to contain the upward trends in health care costs in this country. As a major provider of health insurance to individuals, Golden Rule has little control over the number or frequency of claims that are submitted, and little control over the costs of medical care. Indeed, as the government, health maintenance organizations (HMO's), and large group plans negotiate discounts from hospitals and doctors for medical treatment, those costs are often shifted to individuals insured by Golden Rule which lacks the leverage to demand equal billing.

Golden Rule does not contribute to the problem of rising

health care costs through our own business practices. Our loss ratios are not abnormally low, but reflect normal loss experience for the industry. Our profits are not unreasonable, and we do not attempt to retain monies due on claims of our insureds to enrich ourselves. On the contrary, Golden Rule provides health insurance coverage at prices that are most reasonable compared to other carriers.

Our customers appreciate our modest premium charges and include large numbers of working men and women, senior citizens, students, and other less affluent population segments. We are proud we can provide this vital health insurance benefit to lower income individuals and their families.

Golden Rule has supported reforms which would be of considerable value in containing future costs. We have, for example, advocated loss ratio guarantees to ensure that policyholders do not receive less than the benefit levels our initial pricing anticipated. Should the claims experience be unexpectedly low, the company agrees to refund premiums to the policyholders so that benefits received equal the benefit levels projected for the product.* It is, indeed, ironic that Golden Rule is criticized by some for allegedly engaging in business practices we have been trying to eliminate by statute. We believe other reforms we advocate, including the adoption of medical savings accounts, would similarly restrain health care costs in the future. We hope they will receive careful consideration by the Congress.

---

*Of course, when the loss experience is unexpectedly high, the insurance company must absorb the financial loss under the loss ratio guarantee program.

Conclusion

Golden Rule appreciates the opportunity afforded us by the Subcommittee to appear here today and provide information which may aid the Subcommittee in its ongoing investigation. We are grateful that we were permitted to answer our critics, present factual responses to concerns of the Subcommittee, and set the record straight.

Golden Rule is an exemplary corporate citizen and I am proud of my leadership role at the Company. Through our charitable contributions and financial support of areas where we do business, we have tried to make those communities better places to live. Through our efforts in the fields of civil rights and educational choice programs, we have tried to make our communities places where citizens enjoy greater equality and opportunity. Through our efforts in making health insurance available to less affluent Americans and their families, we have provided health coverage to many of our citizens who would otherwise be unprotected.

On behalf of our employees and policyholders, I thank the Subcommittee for its consideration of our views.

Mr. DINGELL. Thank you very much, Mr. Whelan.

The Chair recognizes now the distinguished gentleman from Colorado.

Mr. SCHAEFER. Thank you, Mr. Chairman.

To start with Mr. Whelan, or anyone that is on the panel, we have heard testimony, as you have here prior, about the aggressive lobbying activities both against and in support of the various State health insurance reform initiatives and implication to some degree that these tactics more or less cross the line from being merely aggressive to improper. I understand that your company, as well as other companies dealing with this issue or other issues, certainly do become involved in this lobbying aspect.

Do you think that your activities with Golden Rule have crossed the line anywhere on various types of lobbying efforts that you have had?

Mr. WHELAN. No, sir. I look at our activities as being forceful and aggressive. They are factually based. We do not put information out that cannot be supported and they are designed to advocate a position, inform members of the legislature and in cases inform our policyholders of what we think may happen.

Mr. SCHAEFER. I understand that you did have a lobbyist in Iowa who more or less may have crossed the line and he was dismissed?

Mr. WHELAN. We have a lobbyist in Iowa who is reported by our person from Iowa this morning in a phone call, threatened that we would use—I think the number reported this morning was $500,000 of expense to lobby against the Department. That was an inappropriate action on his part to use the threat. Whether or not we would expend a sum of money to lobby an issue in the State is a decision the company would make. We have never resorted to using the threats of lobbying as a way to carry through on an initiative.

Mr. SCHAEFER. But that person was dismissed?

Mr. WHELAN. Yes, he was dismissed.

Mr. SCHAEFER. Right away?

Mr. WHELAN. Absolutely. As a result when I learned of it I went to Iowa to meet with the Department, to meet with the domestic industry and to meet with members of the legislature.

Mr. SCHAEFER. I would like you to elaborate on a newspaper article I have here that happened in South Carolina pertaining to the hundred dollar checks that were left on desks of members of the house of delegates. Could you give us a run-down on how this happened and what the situation was?

Mr. WHELAN. I will try. I will tell you what I know about it.

Mr. SCHAEFER. Or anyone else.

Mr. WHELAN. We had made contributions to certain members of the legislature in West Virginia. At the time those contributions were made, there were no issues that the company had an interest in that were active in the legislature. As I understand it, when the checks were brought to the West Virginia Statehouse by a courier. The courier took those in and put them on the desks. I am told that there are no mail boxes in the West Virginia Statehouse for receipt of mail. It was not appropriate to take them into the chamber. It was not at our direction that they be taken into the chamber.

Mr. SCHAEFER. So basically they were just contributions then that just got misplaced or somebody——

Mr. WHELAN. They were contributions that we intended to give to members of the legislature.

Mr. SCHAEFER. I stand corrected. It was West Virginia not South Carolina?

Mr. WHELAN. Yes, sir.

Mr. SCHAEFER. From testimony also that we have heard today and previously, it would appear that Golden Rule engages in litigation quite frequently, both against its own policyholders and against State insurance commissioners who have denied rate increases or performed other acts not to Golden Rule's liking.

Do you agree with this assertion?

Mr. WHELAN. No, I do not, sir. Unfortunately, the business of health insurance does generate litigation, but the litigation compared to the volume of activity of the company is a de minimis amount. We process about 7,500 claims a day each and every day.

I think that the declaratory judgment actions brought by the company between 1990 and 1993 averaged—I think it was 110 at the highest and 43 at the lowest, a small number compared to the litigation or to the claim exposures that are being handled by the company. The same is true in terms of suits brought by others against the company.

There may be in the neighborhood of a hundred brought a year compared to claim volume of 7,500 a day. Our suits against insurance departments also are relatively small numbers. They occur when there is an issue that can't be resolved and we resort to the court for the court's interpretation on the issue of fact.

Mr. SCHAEFER. Let me ask you about the rate increases. Are there some States that you do business in that have laws indicating that you cannot raise rates for a period of 2 or 3 years or something of that nature?

Mr. WHELAN. There are States that have attempted through the departments of insurance to forestall rate increases. To my knowledge, there are not laws that say you can't take the rate increase. There are standards that exist that you have to document that your loss experience justifies the rate increase, but we have encountered States which have not granted rate increases through regulatory delay.

Mr. SCHAEFER. What comes to mind is a situation in the State of Florida where when there were not rate increases for a period of time and then within 3 years, they went up like 38, 32 and 26 percent, quite a sizable jump. What was the reason for something like that?

Mr. WHELAN. The situation in Florida on that block of business was related to regulatory delay where we could not get the Department to approve our rate filings and that extended over a period of 2 years before we finally got relief.

At that point in time, we not only needed the rates that we needed the year earlier, but further rates that were required because the block had gotten older, health care costs had gone up, intensity changed, all the factors that drive health care costs up. So we were in a situation where multiple rate increases were needed over the

next 36 months to catch up to the 36 months where we didn't get rate relief.

Mr. SCHAEFER. In his testimony earlier today, Representative Scorsone mentioned that Golden Rule's rate of complaints per premium dollars was higher than the Kentucky State average. Would you care to expound on that?

Mr. WHELAN. Unfortunately, I am not familiar with that piece of data that the representative used so I can't refute or agree with it. The individual health business is one by its nature that generates lots of inquiries and complaints, especially when you have a situation where you make a claim decision to not pay for something that is not covered and the person resorts to writing to the Department of Insurance for a second opinion.

Mr. SCHAEFER. Is there anything unique about Golden Rule's structure that would explain for a higher complaint rate? Do you have a different structure than other companies of the same nature?

Mr. WHELAN. Our structure is similar to other companies and the thing I don't know is what companies were being compared, whether this was just writers of individual health insurance, whether it was writers of individual and group insurance combined, or whether it was all insurance writers.

Depending on what population was looked at, you will get different complaint ratios. Individual health insurance tends to have more complaints than group health insurance. Life insurance tends to have less complaints than all.

Not knowing what data he was dealing with, I am at a disadvantage to be able to respond and say here is what explains that data.

Mr. SCHAEFER. Individual policyholders, as I understand it—I mentioned this earlier—some two-thirds of them have incomes of under $35,000?

Mr. WHELAN. That is correct, sir.

Mr. SCHAEFER. You also testified that Golden Rule has been instrumental in the adoption of the loss ratio guarantees in States that would favor the implementation of this concept nationwide. Is Golden Rule alone in pushing this concept or have other companies also advocated this position?

Mr. WHELAN. Other companies have advocated it. Specifically, New York Life, Metropolitan Life, and Equitable Life have given Golden Rule permission to use their backing in support of this concept and our efforts to lobby and promote the concept in other States.

Mr. SCHAEFER. You testified that you pay 90 percent of all valid claims within 5 working days or less from the time proof of loss is received and that 98 percent of these claims are paid within 10 working days or less. Your critics may well agree, but assert that since Golden Rule determines whether or not a claim is valid, a large number of claims may still be kept in limbo.

Can you comment?

Mr. WHELAN. That is specifically why we have both the 90 and the 98 percent measure is we don't want to have outliers and we count, when we get to the 98 percent, the claims paid. We are a hawk on getting our business done quickly.

We monitor it, measure it and report it daily because we don't want to have a majority done and have the outlier sitting around getting crusty.

Mr. SCHAEFER. Thank you very much, Mr. Whelan.

My time is up.

Mr. DINGELL. The time of the gentleman has expired.

The gentleman from Texas.

Mr. BARTON. I thank the Chairman. I just want to—we have heard some terribly nefarious things about the Golden Rule Insurance Company and you don't appear to have horns. For the record, do you have a dog?

Mr. WHELAN. Yes, sir.

Mr. BARTON. Does your dog love you and wag its tail when you come home in the evening?

Mr. WHELAN. Yes, sir.

Mr. BARTON. That is usually a pretty good indication of the character; if the dogs are friendly, you are good people.

I want to go back to what Congressman Schaefer asked about. The individual in Iowa who made the threatening phone call to the first Deputy Commissioner was terminated. How long did it take for that individual to be terminated?

Mr. WHELAN. It was a couple of years ago, so I am not sure exactly how long, but it was within a matter of days.

Mr. BARTON. As soon as the corporate leadership found out about the situation, they took immediate and swift action?

Mr. WHELAN. Yes.

Mr. BARTON. If we were to get that individual before this subcommittee under oath to testify, would that individual say that he or she was acting specifically at the direction of the company or was that individual pretty much taking a general set of principles and making a specific threat on their own volition?

Mr. WHELAN. First of all, let me point out, the individual was not a full-time employee, but was working as a lobbyist on contract with us representing our interest in the State of Iowa. That person specifically apologized, acknowledged that they had taken an action that was not approved by the company, apologized for taking that action and admitted that the person understood that the action was inappropriate.

Mr. BARTON. So you had a contract lobbyist with a general contract to lobby for the company on a specific bill and took actions that they thought were in your interest, but that was their decision?

Mr. WHELAN. That was their decision. It was not one that we supported.

Mr. BARTON. A lot has also been made about that the fact that Golden Rule seems to be a habit of filing lawsuits against insurance commissions. Would you care to elaborate on the first lawsuit that you filed in Illinois and why you filed it and how that worked out?

Mr. WHELAN. That first lawsuit was a suit filed a good number of years ago. It was right after the Illinois Department of Insurance brought into existence the agent license testing, and we quickly learned that minorities were unable to pass the exam related to a

question of the question bias, not a question of the measuring competence to do the profession of insurance.

The company has, after reviewing what was going on, brought suit against the Illinois Department of Education and Testing Service for bias in agent licensing.

Mr. BARTON. The bias was that it made it very difficult, if not impossible, for minority applicants to pass the test?

Mr. WHELAN. Yes.

Mr. BARTON. Your company filed a lawsuit against that practice?

Mr. WHELAN. That is correct.

Mr. BARTON. Because the Illinois Commission refused to change the practice?

Mr. WHELAN. That is correct.

Mr. BARTON. What was the end result of the litigation?

Mr. WHELAN. The Education Service agreed to change their test question development process to measure the disparate impact of questions and to select questions or collusion on the test that had the least disparate impact and to measure test results going forward.

Mr. BARTON. So the result of the litigation was that it is now easier for minorities to pass the licensing test in the State of Illinois?

Mr. WHELAN. That is correct, and I might add that the company spent several million dollars pursuing the issue over 10 years.

Mr. BARTON. I wanted to ask you about the issue of cherry picking. Of those that apply for personal insurance with your company, what percent are rejected?

Mr. WHELAN. In the periods of 1990 to 1993, over 90 percent of the people who applied received coverage.

Mr. BARTON. Over 90 percent of those that applied. Do you have any kind of a prescreening test so that you prevent people from applying who want to apply?

Mr. WHELAN. Absolutely not. In fact, we will not provide any underwriting criteria to the market. We tell the producer send the application to us.

Mr. BARTON. So a hundred people walk in off the street and apply for insurance with your company, over 90 percent are accepted. How does that compare to the industry average? Are you above average, below average, or are statistics even kept?

Mr. WHELAN. I am not aware of statistics that are kept so I am not in a position where I can say we are above or below. I think we do a good job of trying to issue coverage on as many people as we can.

Mr. BARTON. Of those you accept, I am told within 2 years, 70 percent of them are out of the pool; is that correct?

Mr. WHELAN. Probably of that magnitude.

Mr. BARTON. Do you kick them out of the pool? Why do they leave the pool?

Mr. WHELAN. Because we buy individual health with after-tax dollars and it is very expensive. If a person who buys our product subsequently gets on with an employer who provides group insurance, they drop our product——

Mr. BARTON. So most of the people who apply for insurance with your company are with independent agents that represent your

company because they are unemployed or self-employed and can't get insurance other places, and you accept over 90 percent. Subsequently they go on to other employment opportunities where there is group coverage or they go to school and so they voluntarily leave the pool because they have a better deal somewhere else?

Mr. WHELAN. That is correct.

Mr. BARTON. That doesn't appear to me to meet any standard definition that I am aware of of cherry picking.

Let's go into these aggressive lobbying practices that your company has been accused of. From what I can tell, the thing that seems to infuriate me the most is that you actually have the gall to write your policyholders in individual States and ask that they contact their representatives on pending legislation.

Is that illegal in any of the States? It is not illegal in Texas. It is not illegal in the Congress. Is it illegal in any of the States for a group, any entity that has a group of individuals that are part of their organization to be contacted by that organization and given information by that organization and then even, heaven forbid, solicited by that organization to contact their elected representatives to voice an opinion on a piece of pending legislation; is there a State in the Nation where that is illegal, to your knowledge?

Mr. WHELAN. Not to my knowledge.

Mr. BARTON. When you do that, do you pay the postage on those letters?

Mr. WHELAN. Yes, sir.

Mr. BARTON. I can't speak for any other Member of Congress, but I have received letters like that that were preprinted, presorted, prepaid and sent to my congressional office and when we called those individuals, we found those individuals did not know those letters were being sent on their behalf, that they had no knowledge.

Have you ever done anything like that?

Mr. WHELAN. When I say we pay the postage on the letters, that is our communication with our policyholders. We may suggest that our policyholder contact their elected member of the State Legislature.

Mr. BARTON. But if they choose to contact their elected representative, that is of their own volition. In other words, you don't send a preprinted postcard to Congressman Joe Barton and say Sam Smith of Texas and don't tell Sam Smith you are doing that.

You contact Sam Smith and say "Congressman Barton is contemplating insurance reform. This is our position on this issue. If you agree, please contact Congressman Barton and tell him so."

Mr. WHELAN. That is correct.

Mr. BARTON. That is aggressive. Did you pick that up from the Association for Retired Senior Citizens or the National Rifle Association or Citizen Action, the National Wildlife Federation? Did you go to a seminar on lobbying on how—I am probably being facetious here.

I want to ask a little bit more serious question. If your company decided it is not worth it, too much hassle, too many problems, we are trying to serve an individual market; it would be a lot easier for us to be in a group market where we only have to deal with one employer and one large organization. If you dropped out of the

insurance market for individuals, who would serve that market? Where would those people get insurance?

Mr. WHELAN. There are a handful of companies left in the business.

Mr. BARTON. What is a handful? A hundred? A thousand? Ten?

Mr. WHELAN. Less than a hundred probably.

Mr. BARTON. I am told that three or four pretty well dominate; is that correct?

Mr. WHELAN. That is correct.

Mr. BARTON. Do you think the government could serve that market as well as the collective private companies that are in the market now?

Mr. WHELAN. I have not seen an example of that happening in the past, so I have my doubts.

Mr. BARTON. So in practical effect, if you and others in your position were to drop out of the insurance market for individuals, the greater likelihood is that many of these people would not have any insurance unless the government decided to come in and do that?

Mr. WHELAN. I think that is a fair conclusion.

Mr. BARTON. I thank you for your answers and I thank the Chairman for his allowing me to ask the questions.

Mr. DINGELL. The time of the gentleman has expired.

The gentlewoman from Pennsylvania.

Ms. MARGOLIES-MEZVINSKY. The lobbyist from Iowa that you dismissed suggested that you were prepared to spend a great deal of time and money trying to get what you wanted in Iowa. One might naturally conclude that you have a substantial market share in the State, but you didn't; is that correct?

Mr. WHELAN. The representative from the Iowa department reported our market share this morning. I could not comment on what it was other than say I will accept his number.

Ms. MARGOLIES-MEZVINSKY. It was one-half of 1 percent.

Mr. WHELAN. That sounds low, but I don't have a basis to argue with him.

Ms. MARGOLIES-MEZVINSKY. You were willing to spend, from what we were told, $500,000 for one-half of 1 percent of the market or whatever the figure was. What do you spend in bigger markets?

Mr. WHELAN. Regarding the Iowa market, the representation made by that individual, as I have already commented, was not something that the company had approved. It was made by him apparently in haste and anger, and it was something that led to his dismissal. So the decision on what we will spend on lobbying is one that we make on a market-by-market based on what is happening and what needs to be done to get a view expressed.

Ms. MARGOLIES-MEZVINSKY. Let's talk a little bit about your efforts in the Ohio individual health insurance market. Didn't Golden Rule attempt to raise the rates of thousands of its individual policyholders by 86 percent in 1989, all in one fell swoop?

Mr. WHELAN. I am sorry. I am not prepared to comment on that. I was advised that the period of time covered by this exam was 1990 to 1993, so my preparation didn't go back into information from that time period.

Ms. MARGOLIES-MEZVINSKY. Could you provide that for the record?

Mr. WHELAN. Surely. It was Ohio?

Ms. MARGOLIES-MEZVINSKY. That is right. This is what we have from The Columbia Dispatch dated February 3, 1989. It was, in fact, what was quoted in this article. We would just like to know if that is correct.

Mr. WHELAN. OK.

Ms. MARGOLIES-MEZVINSKY. Let us assume that it is either correct or somewhat in the ball park. It almost doubles the actual cost of premiums for those policyholders. If you could explain to the committee, justify health insurance premiums almost doubling in a year?

Mr. WHELAN. Let me first comment on the area of health insurance and health insurance rates. We do not like rate increases any more than our policyholders or I suspect any member of the panel that is sitting here today. The rate increases come about because of factors that change the claim cost.

The calculation of the required premium is one that we need to justify to the regulatory body before we get to take the rate. We file it. They must approve it. That calculation is based on the actual claim experience, the underlying inflationary trends in health care, the changes in utilization and intensity, the impact of cost-shifting and the fact that Medicare and Medicaid have for a number of years underpaid providers and the underabsorbed cost of the providers gets pushed around to the rest of the channel and all of those items combine to drive the needed rate increase.

Ms. MARGOLIES-MEZVINSKY. But to the unsophisticated eye, perhaps, would you admit that that is an extraordinary increase?

Mr. WHELAN. Sure. It is an extraordinary increase.

Ms. MARGOLIES-MEZVINSKY. You tried to raise those rates without any formal rate review according to this same article. Is that correct?

Mr. WHELAN. I have already said that I didn't prepare for that time period so I can't comment on the validity of what was reported in the article that you have in front of you.

Ms. MARGOLIES-MEZVINSKY. OK.

Could you make sure that you provide all of that information to the committee as soon as possible?

Mr. WHELAN. Yes, ma'am.

Ms. MARGOLIES-MEZVINSKY. Thank you.

Mr. WHELAN. Could the committee provide us a copy of the article you are referring to?

Ms. MARGOLIES-MEZVINSKY. You say that your company had the public's interest at heart. In fact, on page 4 of your testimony, you claim that "Golden Rule is an ethical, well-managed health insurance provider, a company that strives always to protect its policyholders' best interests."

How exactly does the kind of abandonment that we were referring to before by dropping health insurance protect your policyholders' interests?

Mr. WHELAN. Could you clarify the abandonment of dropping policyholders?

Ms. MARGOLIES-MEZVINSKY. Well, according to the information that we have, there were in this mix 40,000 policyholders who would have been dropped had your request been granted.

Mr. WHELAN. I am sorry. Are we still talking about the Ohio——

Ms. MARGOLIES-MEZVINSKY. Yes.

Mr. WHELAN. I think I need to repeat what I said before. I am not prepared to talk about that because I am not familiar with the facts at this time. I would be pleased to respond once we have had a chance to review things.

Ms. MARGOLIES-MEZVINSKY. Let's move on to the North Carolina——

Mr. DINGELL. If the gentlelady would yield—Mr. Whelan, do you recall your discussions and correspondence with the Ohio Department of Insurance on this matter?

Mr. WHELAN. No, sir. I do not.

Mr. DINGELL. Do you recall that you requested an 86 percent increase in your fees on the insurance?

Mr. WHELAN. I don't dispute that we may have requested an 86 percent increase, but I have not reviewed that in preparation for this hearing today.

Mr. DINGELL. Do you recall that you threatened to drop 40,000 people unless the Department approved your rate increase within 2 days?

Mr. WHELAN. Sir, I have not reviewed those facts for this hearing today, so I cannot say that I recall them or don't recall them.

Mr. DINGELL. Would you want to tell us specifically that you did not either request an 86 percent increase or that you did not threaten to drop your Ohio clients unless the department approved your rate increase within 2 days?

Mr. WHELAN. Our position on rate increases, when we have gotten to the point of taking the action to non-renew, a block of business has been driven from the losses experienced by the company and the fact that we could not continue those losses without questioning the ability of the company to continue.

When we look at our obligation at that point in time, we are looking at our obligation to all of our policyholders and we don't take any enthusiasm or solace in having to non-renew, but we also believe that we must preserve the financial integrity of the company to deliver the benefits to all the policyholders going forward, including those in all the other States who are paying the adequate rates.

Mr. DINGELL. I am curious; how would you get in a position where you had to find yourself choosing between your responsibilities to your other policyholders or getting an 86 percent increase in your rates and to have to choose at that point between those two on the basis of a 2-day requirement that you drop 40,000 people in the State of Ohio?

How would you get yourself in that kind of position where you had to make that kind of choice?

Mr. WHELAN. Mr. Chairman, the thing that I don't know is what the transaction consisted of that was going on at that time and where this piece of communication that you have that I don't have fits into that entire transaction. Without that and without the refreshing of what was going on at the time, I can't comment in a relevant fashion on what was happening.

It is possible that this could have been the 15th communication that is spread out over a long period of time that led to what was in that letter. I don't know, sir.

Mr. DINGELL. The Chair thanks the gentlewoman.

Mr. WHELAN. Mr. Chairman, let me give you a further example of the impact of these rate situations. In North Carolina——

Mr. DINGELL. I guess it would be helpful if you would tell us about the impact of the rate increase or the failure to receive the rate increase. Do you know whether you got the rate increase or not?

Mr. WHELAN. Sir, I have already said numerous times that you are talking about a circumstance and an action in Ohio in 1988 or 1990 that was not indicated as the time period this committee was looking at and I did not prepare for it. Had I known it was part of what you were looking at, I would have prepared for it.

Mr. DINGELL. Very well.

The gentlewoman from Pennsylvania.

Ms. MARGOLIES-MEZVINSKY. Mr. Whelan, it has been brought to our attention that Golden Rule frequently sues insurance commissioners and other State officials to get what you want. Your activities in Florida prompted Insurance Commissioner Tom Gallagher to brand you as "a bait-and-switch insurance company and a rip-off artist."

Apparently you couldn't afford to leave the Florida market altogether so you opted to sue Commissioner Gallagher, didn't you?

Mr. WHELAN. Yes, ma'am. The situation that occurred in Florida was the Florida department was demanding that we use a 5-year trend in the setting of our rates for the medical—the senior citizens Medigap product. What that means in layman's terms is we would need to charge a premium today that would be adequate for a 5-year period of time. That substantially increases the cost of coverage to seniors.

We opposed that. There was nothing in the Florida law that required it. We didn't think it was fair to the customers to cause us to have to charge them that premium simply because the Florida department didn't wish to have to deal with the problem of rate increases.

In the process of that activity, when the Florida department refused to approve the rates for that product, we decided we would withdraw our senior citizens product and we decided that we would advertise to the seniors and tell them what was going on. We didn't think it was good public policy to cause people of that age to pay a premium that would be adequate for 5 years and some of them may not be around for the 5 years to enjoy the benefit of that.

Ms. MARGOLIES-MEZVINSKY. Could you provide the committee with documentation on how you reached those numbers?

Mr. WHELAN. Yes. We would be pleased to.

I would repeat, they wanted us to increase the rates and we said no to them, and as a result, the commissioner went to the TV and branded us as "bait and switch" and other items which led to our suit.

Ms. MARGOLIES-MEZVINSKY. Is that case still pending?

Mr. WHELAN. Yes, it is.

Ms. MARGOLIES-MEZVINSKY. It has been said that lawsuits like that could really have a chilling effect on the ability of State officials to regulate this industry. That was not your intent?

Mr. WHELAN. No. Our intent was to protect the honor and integrity of the company name. The characterizations that were being made of us on TV by the Commissioner of Insurance as part of his campaign for elected office could have a chilling effect on the ability of the company to do business also.

Ms. MARGOLIES-MEZVINSKY. Thank you very much.

Mr. DINGELL. The time of the gentlewoman has expired.

Mr. Whelan, the lights that you see on the clock up there and the bells which you have heard indicate that we have approximately 5 minutes to answer our names on another vote on the House Floor, so we will adjourn for a period of 15 minutes and return then for continuation of our discussions.

The committee will stand in recess for 15 minutes.

[Brief recess.]

Mr. DINGELL. The subcommittee will come to order.

Mr. Whelan, the subcommittee heard testimony this morning which said that in the 1990 election, Golden Rule spent over $1 million in independent expenditures to try and defeat the Florida Insurance Commissioner because the commission had objected to Golden Rule's cancellation of major medical policies for 20,000 Florida policyholders.

Is that true or not true?

Mr. WHELAN. Mr. Chairman, I don't know that that number is true. It is not a number that I looked at before coming here. I would be pleased to look it up for you.

Mr. DINGELL. Did Golden Rule interest itself in the election of the Florida Insurance Commissioner in 1990?

Mr. WHELAN. Yes, sir. We did.

Mr. DINGELL. Did you make independent expenditures in that election?

Mr. WHELAN. I believe we did, sir, but I need to check that.

Mr. DINGELL. You believe you did? Your best recollection is that you did?

Mr. WHELAN. Yes, sir.

Mr. DINGELL. Did you make an expenditure against the Florida Insurance Commissioner?

Mr. WHELAN. Yes, we did.

Mr. DINGELL. Do you know how much you expended?

Mr. WHELAN. That is the piece that I didn't look up before coming here and I don't think that I should speculate on that.

Mr. DINGELL. Did you spend a large sum or a small sum?

Mr. WHELAN. Those are relative terms, sir, and I don't how much we spent.

Mr. DINGELL. Would $1 million be more than you spent or less?

Mr. WHELAN. I don't have a number so I can't respond to it in terms of did we spend $1 million or was it more than $1 million or less than $1 million. I just don't know.

Mr. DINGELL. Did you spend more than $100?

Mr. WHELAN. I suspect we spent more than $100.

Mr. DINGELL. More than $1,000?

Mr. WHELAN. Yes.

Mr. DINGELL. More than $10,000?

Mr. WHELAN. Probably.

Mr. DINGELL. More than $100,000?

Mr. WHELAN. I don't know.

Mr. DINGELL. If I were to say you did, would you deny it?

Mr. WHELAN. No, sir. I would volunteer to look it up because I don't know.

Mr. DINGELL. So you did make a large expenditure against the Florida Insurance Commissioner? Tell us why you did that.

Mr. WHELAN. We made the expenditure to address the issue on the raising of rates on senior citizens.

Mr. DINGELL. The raising of rates on——

Mr. WHELAN. On senior citizens. The issue that arose with the Florida Insurance Commissioner was regarding the rating on the Medigap policy. We were filing a new policy for approval.

The Department came back and said they refused to approve our product unless we used 5-year trends in setting the rates. That means that we must charge a premium going in that would be adequate for the full 5 years. That translates to a premium that is much higher today for the insured than they would otherwise have to pay.

There was nothing in the Florida law that required that. We didn't think it was fair to our policyholders to do it, and it would have been to our economic advantage to do it, but we didn't think it was fair to the policyholder. We disagreed with the commissioner over that matter. We refused to market the product, the commissioner took action against us and we responded——

Mr. DINGELL. Is it unusual for an insurance company to make a large expenditure against the election of an insurance commissioner in a State like Florida?

Mr. WHELAN. I don't know whether it is usual or unusual because I don't know the practices of other companies, sir.

Mr. DINGELL. Is this the only time that your company has done in this?

Mr. WHELAN. In an insurance commissioner race. Yes, sir.

Mr. DINGELL. Are you aware of other companies having made major expenditures against an insurance commissioner of a State?

Mr. WHELAN. I just said I don't know.

Mr. DINGELL. Did you have any correspondence with the commissioner before you did this?

Mr. WHELAN. There was correspondence and discussion with the department over the 5-year trending, the lack of support for it, the negative impact it would have on the insurance purchaser, all to no avail in getting the product viable for sale.

Mr. DINGELL. Would you make that correspondence available for the committee?

Mr. WHELAN. Yes, sir.

Mr. DINGELL. When did you inform the commissioner that you were going to make an expenditure against him?

Mr. WHELAN. I don't know.

Mr. DINGELL. Were you involved in decisions of this nature?

Mr. WHELAN. At that time, yes, sir.

Mr. DINGELL. Was anybody else in the company involved?

Mr. WHELAN. I am sure most of our senior management discussed it.

Mr. DINGELL. As chief executive officer, you would have been involved in the matter rather early, would you not?

Mr. WHELAN. Yes, sir.

Mr. DINGELL. Would I be unfair if I were the insurance commissioner in Florida and I were to infer that this was an attack particularly directed at intimidating me?

Mr. WHELAN. I think it would be unfair. The department was pursuing tactics to intimidate the company. I must go back and emphasize that the impact was on the senior citizens in Florida.

The impact of the decision they wished us to make in terms of our rating would have caused the price of our product to be much higher in the marketplace, to cause the senior citizens to have to pay more for the coverage, more than they would necessarily have to pay for coverage today, and we said no to that.

Mr. DINGELL. Let's say that I were the successor to that insurance commissioner or I were the insurance commissioner in Georgia or Alabama; would I be incorrect in inferring that if I didn't do what you wanted, that I would find you folks down there spending a million dollars against me?

Mr. WHELAN. I think—I would not make the jump from Florida to say that if you didn't do what we want, that we would take action. We have situations in departments all the time where the decisions are not the decisions that we would want, and we accept those and move on.

Mr. DINGELL. I am just a poor Polish lawyer from Detroit walking down the street in Florida and I see that Mr. Whelan's Golden Rule Insurance Company is spending a million dollars against the insurance commissioner. Would I be unjustified in walking away with the assumption that you were either punishing or intimidating him?

Mr. WHELAN. We decided to take a voice in that election campaign after the insurance commissioner took after us on the public airwaves making comments that were unfounded about the company being a bait-and-switch company and other derogatory comments. In addition, the Department of Insurance dispatched to Golden Rule a market conduct examination team.

When that market conduct examination team showed up in our offices, we asked them why they were there. They didn't know. That was punishment to Golden Rule for not going along with raising the rates on our Medigap policies.

Mr. DINGELL. So you had several reasons for running the ads; is that correct?

Mr. WHELAN. Yes, sir.

Mr. DINGELL. Now, I have an article here from The Orlando Sentinel, Friday, January 31. It says, the commissioner's ads were in response to the company's TV ads that accused him of trying to increase the price of Medicare supplement insurance by requiring insureds to base their premiums on 5-year projections, a practice known as trending.

The newspaper says the commissioner made his response in response to your ads. Do you recall whether that is a fair statement or not?

Mr. WHELAN. I don't recall the sequence in which things happened.

Mr. DINGELL. This article is written on January 31, 1992. I assume that this is reasonably contemporary. Should I be prepared to challenge this?

Mr. WHELAN. I am sorry. I don't understand the question.

Mr. DINGELL. Should I be prepared to challenge the statement that is in the paper about why the commissioner made his presentations on television on this matter? He said he did it in response to your ads.

Mr. WHELAN. The situation occurred in Florida because we challenged the commissioner on the necessity to use a 5-year trend in calculating health insurance rates for senior citizen products. He responded with a personal attack on the company.

We didn't attack the commissioner of Insurance in our ads. We went to the public to tell them about the trending requirement by the Florida Department of Insurance and what that would do to the rates on senior citizen products.

Mr. DINGELL. Well, now, in June, we heard from Mrs. Jean Shaheen from the New Hampshire State Senate. She testified in this room that the recent legislation is designed to make various reforms in health insurance regulation and that it had a very broad coalition of support, specifically the Governor and the Commissioner of Health and Human Services, legislators and leaders in both bodies supported the reforms, and three of New Hampshire's largest health providers supported the legislation.

Golden Rule launched a massive effort to scuttle these reforms. What I find curious is that Golden Rule writes only about 1 percent of the coverage of the insured population of the State of New Hampshire. Ms. Shaheen noted that Golden Rule, in fact, deliberately attempted to confuse the issue by running a series of radio ads in the metropolitan areas of New Hampshire opposing the legislation and urging the people to call their legislators.

You write 1 percent or less of the insurance in New Hampshire in the area of health care. Why would you go into an extensive expenditure for radio ads of this kind?

Mr. WHELAN. Well, first of all, Mr. Chairman, the New Hampshire market, as with all the markets in which we do business, are important to us. The ability to continue to provide an affordable product to our customers is also very important.

The reforms that were contained within the New Hampshire legislative proposal, specifically the guaranteed issue, the community rating which was introduced initially as pure community rating, the limitations on preexisting condition exclusions and the guaranteed renewal, all were a set of circumstances which would have a predictable impact of substantially increasing the cost of insurance for the people who buy from us.

Those people tend to be low-income Americans. Nobody else is looking out for them.

We heard from the Representative from Colorado this morning that health care reform for individuals hasn't moved in his State because they don't have a constituency looking out for them. We were looking out for our policyholders' interests.

It would be easy for us to go along and say let's do community issue, community rating. We know what the impact of that will be. The impact of that will be predictably higher costs.

There have been a number of instances where those provisions have been put into place and that has been the impact. The impact also is people exit the market, fail to buy because they now don't have the uncertainty of can I get coverage? They can simply wait until they are ready to use coverage and then buy. That further drives up the cost.

We have seen that in a Society of Actuary study that show that the claim cost on small group coverage between guaranteed issue coverage and underwritten coverage was 50 percent higher in the second year, same plans 50 percent higher, and I believe the study was multi-billion dollars of coverage; so it was not a small sample.

We have seen the example in New York where a year ago the State put in guaranteed issue community rating and 1 year later, 500,000 people or more have left the individual and small group insurance marketplace in New York; 500,000 less covered people.

What happened in New York, before the change, there were rates by age. After the change, there was one rate. That resulted in a substantial increase in the rates for the young, a discount for the rates on the 55 to 64 segment. It now appears 1 year later that the rates being paid by everybody in the marketplace are higher than the 55- to 64-year-old person was paying before, so what this reform has done is it has taken the entire rate curve in the New York marketplace and has now made it higher 1 year out than the highest person was paying before, and 500,000 people or more have left the market.

It is those reasons that cause us to stand up and take exception to guaranteed issue community rating because they won't work, and we value the marketplaces that we serve and we are willing to go to our policyholders and tell them the consequences of planned action before it occurs.

Mr. DINGELL. Earlier today, Mr. Scorsone testified as follows: "Golden Rule sent several doomsday letters to its policyholders—letters that purported to give alarming examples of certain dire provisions in the bill. That the examples were distortions seemed irrelevant. The letters achieved their goals, which was to spread fear and confusion. Legislators received many a call from frightened senior citizens."

I hear that you have sued the regulators. You interest yourself very actively in the matter in New Hampshire. You have put ads on against the Commissioner of Insurance in Florida.

Aren't we seeing a pattern here of attempts by Golden Rule to intimidate and coerce the regulators in the conduct of their business?

Mr. WHELAN. No, sir. I don't think so. I think what you are seeing is the willingness to tell the people who buy our products, the impact of planned changes before the changes come through.

The impact in New York was predicted by many before the change went through. There was an enormous lobbying effort by most of the insurance industry. Golden Rule does not write in New York, so we were not involved in that, but there was an enormous

lobbying effort to prevent the change in New York from going through.

They went through. One year later, the predictable outcomes have occurred. We are simply in Kentucky and in New Hampshire telling the customer, this is what will happen if these changes occur. The material that we sent out was factually based. It was based on actuarial analysis, and it is material that we would stand behind.

Mr. DINGELL. If you were saying that this transpired in one State only, I would assume that that would be an arguable case. The committee has now heard testimony from officers of seven different States, regulators in the insurance regulatory agencies, members of the Senate and the State legislature, and their testimony is that Golden Rule tries to intimidate officials, that your data is questionable. And, for example, when Senator Sheehan challenged your claims about what her reforms would do, you threatened to sue her.

I am trying to understand. If it were one State alone, we could be fairly comfortable, say, that it is just a difference of opinion between us and the regulators or the State senators. But here you have got seven States. How are we to say this is not a pattern of behavior? We are confronted with the probability that either there is a pattern of behavior on your part, there is a pattern of behavior on the part of the States and the regulators. Which is it?

Mr. WHELAN. Well, sir, the company does go to its policyholders and does inform the policyholders of the impact of planned legislation. As far as I know, there is nothing in the laws of the States or the laws of the United States that says that we are barred from taking that action. We do this because we believe that our policyholders who have to pay for their product with after-tax dollars should be informed beforehand.

Now, we could sit quietly and let these reforms go through. It wouldn't make much difference to us because we are going to collect the premium, we are going to pay the claims tomorrow, and we are going to get more premium. It will be higher. Unfortunately, there will be less players, less participants, market participants left because people won't be able to afford it.

Now, if our taking a position on behalf of our policyholders is a pattern of practice, yes, it is. We will willingly do that. We have demonstrated our willingness to do that. The impact we are talking about is not one on Golden Rule. The impact we are talking about is one on our policyholders.

As relates to the incident with Senator Sheehan in New Hampshire, she made a personal defamatory attack on Golden Rule in the legislature. We responded by sending her a letter cautioning her that the comments that she made were defamatory and that if they were made again in a public venue, we would consider taking action.

What she commented about Golden Rule were not correct. We did not lie in terms of the information that we presented. We are not greedy profiteers. We are attempting to service an end of the marketplace that is underserved and to provide an affordable product that our customers can afford to have to protect them when they get ill.

Mr. DINGELL. Well, let's talk about Colorado. Senate Bill 114 guaranteed health insurance access for small businesses. It also changed the law so that Golden Rule could no longer pick whom it wanted to choose for the purpose of offering coverage. Now, this is called, I guess, outside the industry but not inside the industry, cherry-picking. I understand that the industry has a more technical description of that particular kind of behavior.

The bill, however, as Representative Coffman told us, was sponsored by members on both sides of the aisle, Republicans and Democrats alike. As a matter of fact, it received widespread backing by the rest of the insurance industry.

Now, Golden Rule didn't like the rules changing on them, and indeed it is fair to say that you disliked the new rule so much that you hired a telemarketing company to call Colorado small business owners urging them to tell their legislators to vote against the bill; isn't that true?

Mr. WHELAN. Yes, sir, we did.

Mr. DINGELL. Well, here I have got a letter to Senator C. Jean Sheehan, 73 Pertinence Road, Madbury, New Hampshire. The letter goes as follows: "Dear Senator, this office represents the interests of Golden Rule Insurance Company, the Illinois corporation," and then there are some other things said. "I have been asked to contact you regarding your comments before the House Commerce, Small Business and Consumer Affairs Committee on Thursday, April 7. Your statement as reported by the Fosters Democrat include, and then you quote, Golden Rule has resorted to lies and half truths in an attempt to defeat this legislation. The out-of-state hucksters could care less about New Hampshire citizens, let alone their health. Far from following the golden rule, this company breaks all the rules to make sure that the gold goes to their bottom line."

Then these statements: "These statements are false, malicious and defamatory and as such represent libel per quod if not libel per se. Similar future comments if made outside the protective cocoon of the legislative chambers may be actionable and appropriate for consideration by a court of competent jurisdiction." Then it is signed by Edgar R. Lantis.

It is not exactly a friendly letter, is it?

Mr. WHELAN. Well, sir, taking an attack on the company and calling us hucksters and resorting to lies and half truths is also not very friendly either. In any of our lobbying we have never resorted to personal attacks. We have resorted to the presentation of information on the potential consequence of planned legislative action. We have informed people. We have asked them to take action, but we have never attacked someone in terms of their veracity, their character, their citizenship.

Mr. DINGELL. You hired a Florida telemarketing company, as you have told us, to call small business owners in Colorado urging them to tell legislators to vote against the bill. How much did you spend on that?

Mr. WHELAN. I don't know, sir. I would be pleased to find out.

Mr. DINGELL. It cost a goodly sum of money, did it not?

Mr. WHELAN. I am not sure that it was a goodly sum of money.

Mr. DINGELL. Doesn't sound to me to be inexpensive if they are going to be making long distance calls from Florida to Colorado urging the legislators out there to vote against the bill. That could not have been an inexpensive undertaking, could it?

Mr. WHELAN. I am not sure that I would agree that it was an expensive undertaking.

Mr. DINGELL. I said inexpensive.

Mr. WHELAN. You said inexpensive, but the opposite of inexpensive is expensive, and I don't agree that it was an expensive undertaking. But I don't have the numbers so I can't comment further on it.

Mr. DINGELL. Well, here you have Republicans, Democrats, fairly major support in the industry. Golden Rule is out there all alone attempting to kill the bill, and you hired a Florida telemarketing company to call businessmen to have the legislators vote against the bill. And the curious fact of it all is that, at this time, you weren't even in the small group market. Now, why were you engaging in this effort on a matter where you weren't even in the market?

Mr. WHELAN. Because we market both individual and small group coverage, and the Colorado market is a market that is attractive to us. It is one that we have a presence in the individual business. It is one that we would consider marketing the small group product in.

Mr. DINGELL. You had virtually nothing in the Colorado market at this time, though, did you?

Mr. WHELAN. I am sorry, sir?

Mr. DINGELL. You had virtually no interest in the Colorado market at this—in this particular market in Colorado at this particular time, did you?

Mr. WHELAN. We had no business flow in the small group marketplace. We had an interest in the small group marketplace.

Mr. DINGELL. Well, here now we are looking at New Hampshire. You have Kentucky. You have only a small part of the traditional indemnity insurance market in each of these States. In this particular case in Colorado, you have about 1.4 percent or about $12 million worth; is that right?

Mr. WHELAN. 1.4 percent of what, sir?

Mr. DINGELL. Of the Colorado market.

Mr. WHELAN. Well, the difficulty I have in responding to those numbers is I am not sure in that case what is the denominator of the fraction. The numerator is, obviously, our premium, but it makes a lot of difference what you are measuring it against. If you measure it against insurance premiums in total, our position in the marketplace would be very small. If you measure it against individual insurance premiums, if you are looking at the individual marketplace, it would be a higher number. But in this case you are using a 1 percent number, and I am not sure what the other side of that is, so——

Mr. DINGELL. Would 1 percent be an incorrect estimate?

Mr. WHELAN. Of our position in the individual health insurance market or in the total insurance marketplace?

Mr. DINGELL. In Colorado.

Mr. WHELAN. Of the individual health insurance market in Colorado?

Mr. DINGELL. Of the traditional indemnity insurance market in Colorado.

Mr. WHELAN. Tell me what the traditional indemnity insurance market means, sir.

Mr. DINGELL. Well, the particular market that we are referring to was one which the legislation would affect.

Mr. WHELAN. Well, the legislation you were talking about a minute ago was the small group legislation. We have also been talking about the individual indemnity marketplace, the people who buy individual products, and my question back to you for clarification is, what market are we talking about?

Mr. DINGELL. Mr. Coffman, you were testifying on that. You made the allusion. Tell us what you meant, if you please.

Mr. COFFMAN. Mr. Chairman, the—first of all, I think the article refers to Senate Bill 114. It was actually a couple years before, but my bill, that they did lobby against, affected both individual and small group market as it was initially proposed, yes, sir.

Mr. DINGELL. Oh, thank you. Well, what percentage of the markets referred to, Mr. Whelan, did Golden Rule have an interest in?

Mr. WHELAN. What percentage of the individual market did we have?

Mr. DINGELL. Yes.

Mr. WHELAN. I don't know our exact market share in Colorado.

Mr. DINGELL. Rather small, was it not?

Mr. WHELAN. $12 million market is not small for us, sir.

Mr. DINGELL. Now, we have the Director of Public Affairs for the greater Denver Chamber of Commerce. He said if you are a bad risk, you are not going to be covered by Golden Rule. Is that true?

Mr. WHELAN. I don't agree with that characterization.

Mr. DINGELL. If you are a bad risk, you are going to be covered by Golden Rule?

Mr. WHELAN. Well, first of all, I don't know what he means by bad risks. If you look at our underwriting practices, about 90 percent of the people who apply for coverage get coverage. Some people get rejected. Some of those rejections are for nonmedical reasons.

In addition, you know, we have been an advocate, a long-standing advocate, for universal access to health care coverage. We have been a supporter of and have worked with many States to try and cause State-based community high-risk pools to be formed for those folks who cannot qualify for an individual product. We push for that.

We do not do demographic underwriting. We do not do economic underwriting. Economic underwriting is a concept where some would suggest, because of the low-income levels, you shouldn't write certain risks because they will lapse their coverage. We make no economic or demographic criteria in our underwriting decisions.

Mr. DINGELL. Well, let's move to Kentucky. Now, Representative Scorsone told us earlier the reforms would make it illegal to refuse to insure sick people. Those were the reforms that you disliked, and you disliked them sufficiently that you sued the State Commissioner of Insurance there; is that right?

Mr. WHELAN. I don't think we did sue the State Commissioner in Kentucky.

Mr. DINGELL. Well, Mr. Scorsone says you did.

Mr. WHELAN. Mr. Chairman, we—the suit that we brought in Kentucky was against the Department of Insurance challenging the constitutionality of the law. It was not a suit against the Commissioner personally.

Mr. DINGELL. But you sued—you sued the State agency or the Commissioner's?

Mr. WHELAN. Challenging the constitutionality of the law, yes, sir.

Mr. DINGELL. State officials in Kentucky were very much concerned about the action. The Governor was quoted as saying that your suit was no surprise because in the debate earlier this year you did everything in your power to defeat their efforts to achieve meaningful health care reform. Moreover, the Secretary of the State Cabinet for Human Resources said that Golden Rule was claiming a constitutional right to gouge the citizens of the State.

Other lawmakers attacked your tactics. The Senate Budget Chairman, Mike Maloney, called your company not a nice word. As Mr. Scorsone told us, when the Human Resources Secretary heard you sued him, he said your company name should be changed to golden shaft.

Now, is this an example of a narrow little skirmish in Kentucky or is this a major fight?

Mr. WHELAN. Well, the issue in Kentucky, the proposed law included community rating and guaranteed issue. We have opposed those. We have opposed them in Kentucky. We have opposed them elsewhere. We opposed them not because of the economic impact on Golden Rule but the economic impact on our customers.

Mr. DINGELL. You were the only insurance company that did that, though, weren't you?

Mr. WHELAN. I don't believe that is correct, sir. I believe there were a number of companies in Kentucky that opposed the legislation.

Mr. DINGELL. It is our understanding that Golden Rule also ran ads saying, "Kentucky lawmakers are ready to hand control of your health care over to the bureaucrats." Furthermore, the ads went on, saying, "do you want the same people who fix potholes in charge of health care?"

Now, I wonder if you regard this as really a useful public comment?

Mr. WHELAN. We do, sir, because we were concerned with the direction that the State was taking and the impact it would have on people who have to buy individual insurance coverage. It is more easy for companies to go along. It would be easy for us to roll over and say, well, at the end of the day this is not going to hurt us. But the reality is it will hurt the people who buy our product.

Mr. DINGELL. Let's go on. You sued departments and insurance commissioners in Missouri, Ohio, Pennsylvania, South Dakota and Iowa. Is that true?

Mr. WHELAN. We have sued different States from time to time on issues to get resolution where there were disagreements.

Mr. DINGELL. Well, here is what you and Golden Rule have had. You have had serious problems with legislators and/or regulators in Iowa, Florida, Missouri, North Carolina, South Carolina, Ohio, Colorado, Pennsylvania, North Dakota, Kentucky, Vermont and New York. Those are the names that come immediately to mind.

Now, what exactly is the problem between Golden Rule State commissioners, legislators and other officials and even other industry representatives? Why is your company so thoroughly involved in either litigation, advertising against commissioners or legislators, writing nasty letters and doing all these things? We don't hear these things about most of the other people in the business.

Mr. WHELAN. Well, first of all, I don't know that your list is correct. I do know that we do not do business in New York, so I find a suit between us and the New York Department of Insurance to be suspect.

Mr. DINGELL. Let's go over the list. Florida, Missouri, North Carolina, South Carolina, Ohio, Colorado, Pennsylvania, North Dakota, Kentucky, Vermont, New York, and we are talking here about serious problems that you have had with legislators or regulators in all of these States. Are you telling me that any of these States should not be included on the honor roll or——

Mr. WHELAN. Well, I think I did say that we don't do business in New York. We are not an admitted company in New York, so I doubt very much that there has been a matter between Golden Rule Insurance Company and the New York Department of Insurance.

Mr. DINGELL. Were you at one time admitted to New York?

Mr. WHELAN. No, sir, we are not admitted to New York. We never have been admitted in New York.

Mr. DINGELL. Have you tried to sell it in New York?

Mr. WHELAN. You cannot sell insurance in a State in which you are not admitted. We have not done business in the State of New York.

Mr. DINGELL. Let's exclude New York. You have had serious problems with legislators, regulators in all the other places. Are there any other folks out there that we shouldn't include on the list?

Mr. WHELAN. The fact that we filed suit in a State should not be taken as an indication of problems with the regulators or legislators as much as it is resorting to the court as the ultimate resolver of a disagreement that starts at the regulatory process below.

The regulatory process does provide for the company and for the regulator for that matter to have resorts to the court for a decision on a matter that has gone through the regulatory process below. A lot of these disputes resolve around rates. Rates in individual health insurance are very highly regulated. We have had a number of instances where the rates—disputes could not be adequately resolved in the regulatory agency below and the administrative procedures, and we have therefore resorted to the court to get a resolution on the matter.

Mr. DINGELL. Well, let's talk about the A.M. Best, A-plus rating of your company. Let's talk about your organizational structure and financial practice. We have examined some matters in the hospital

industry. We found them enlightening in terms of establishing accountability and following the money. Golden Rule Insurance Company is a private company, isn't that correct?

Mr. WHELAN. That is correct, sir.

Mr. DINGELL. You are not listed on any exchange?

Mr. WHELAN. No, we are not.

Mr. DINGELL. Now, as a result of what are clearly very savvy business practices, Golden Rule claims something like $1.1 billion in assets; is that correct?

Mr. WHELAN. Yes, sir.

Mr. DINGELL. Golden Rule Insurance Company is owned by a holding company. That is, Golden Rule Financial Corporation which is located in Delaware; is that right?

Mr. WHELAN. That is correct.

Mr. DINGELL. Who is it that owns Golden Rule Financial Corporation?

Mr. WHELAN. There are several shareholders of Golden Rule Financial Corporation.

Mr. DINGELL. Golden Rule Insurance Company owns 1,782 shares of Golden Rule Financial Corporation. Does it not?

Mr. WHELAN. It owns some shares. I am not sure that that is the right number.

Mr. DINGELL. Now, does Golden Rule Insurance Company own all the shares for Golden Rule Financial Corporation?

Mr. WHELAN. No, sir. Golden Rule Insurance Company has a very minor number of shares. If it is 1,782, I will accept your number. I don't know it independently.

Mr. DINGELL. How many other shares are there, and who are the owners of these other shares?

Mr. WHELAN. The total shares are probably in the 500,000 to 600,000 level. There are two principal holdings. There is a partnership called Golden Investments, which is a partnership of the Rooney family.

Mr. DINGELL. Golden Investments. Who is the partnership?

Mr. WHELAN. It is a partnership of the Rooney family, and that partnership has the majority shares of the company. And then there is another former officer of the company whose family—who he and his family own about 40 percent of the company. And then there is a handful of other shareholders.

Mr. DINGELL. Now, Golden Rule Insurance Company and Golden Rule Financial Corporation have a number of affiliates, do they not?

Mr. WHELAN. Yes, they do.

Mr. DINGELL. Those would be Golden Rule Financial Corporation, Golden Rule Insurance Company Adventures, Inc., Allsavers Insurance Company, Central State Securities, Inc., Executive Systems, Inc., Medical Savings Administrators, Inc. and Rooney Life Insurance Company; is that right?

Mr. WHELAN. Yes, sir.

Mr. DINGELL. Are there any others?

Mr. WHELAN. I don't know that you have gotten them all, but I think you have got substantially all the business activity.

Mr. DINGELL. For the record, would you submit an organizational chart of the corporation, the insurance company and the affiliates?

Mr. WHELAN. Yes, sir.

Mr. DINGELL. Can you tell me who owns the affiliates, please?

Mr. WHELAN. The Golden Rule Financial Corporation owns Golden Rule Insurance Company, and Golden Rule Insurance Company, I believe, owns all of the other subsidiaries. My hesitancy is with Central State Securities and whether that is a subsidiary of Golden Rule Financial Corporation or of the insurance company, and I am not positive of that.

Mr. DINGELL. Now, Golden Rule has described A.M. Best Company as the leading independent analysts of the insurance industry. The Best Company says the affairs of your company are under the direction of the Chairman of the Board, J. Patrick Rooney, who has been associated with the company since 1948. President and Chief Executive Officer John M. Whelan has been with the company since 1979; Executive Vice President and Chief Operating Officer; Teresa A. Rooney, who has served in multiple capacities with the companies since 1978. Is that a correct description of how things are done there?

Mr. WHELAN. Yes, sir.

Mr. DINGELL. Mr. Whelan, I am a little confused about who does what at Golden Rule and who ultimately makes the decisions of Golden Rule about corporate positions on legislative proposals, whether you sue a commission or department or not, whether to seek a rate hike, when to and when not to, and when to expend money on television programs, on State insurance commissioner elections or other matters.

You are the Senior Vice President and General Counsel; is that right?

Mr. WHELAN. No, sir; I am the Chief Executive Officer.

Mr. DINGELL. Chief Executive Officer. I am sorry. You are Senior Vice President and General Counsel, and your outside counsel told our staff about a month ago that you and the board generally made day-to-day decisions. But ultimately the final word came from you, Mr. Rooney and Ms. Rooney; is that correct?

Mr. WHELAN. That is correct, sir.

Mr. DINGELL. Now, what are the roles of the three of you? Have they changed at all?

Mr. WHELAN. Mr. Rooney is Chairman of the Board. He stepped down from the role of Chief Executive Officer in 1990. As the Chairman of the Board, he plays a role as the leader of the board in supervising senior management. He is also involved in our public policy and our governmental affairs activity, and our Governmental Affairs Department reports to him.

The affairs of the insurance company are under my direction. Teresa Rooney is our Chief Operating Officer. Together, we are responsible for the day-to-day operations, and recently we made a switch in the holding company, Golden Rule Financial. I was President and Chief Executive Officer. Teresa Rooney was Executive Vice President, Chief Operating Officer. And in July we switched those roles, and she became the chief executive of the holding company.

Mr. DINGELL. All right. Now, according to A.M. Best, between the years 1988 and 1992, the company paid shareholder dividends totaling about $28 million to its parent corporation; is that correct?

Mr. WHELAN. If it is what was reported in the past, yes, sir.

Mr. DINGELL. What did the holding company do for that?

Mr. WHELAN. The holding company—first of all, the holding company has $170 million invested in the insurance company. We are the owners of the insurance company.

Mr. DINGELL. So this is just a return on investment; is that right?

Mr. WHELAN. The dividend up to the holding company is simply a return on investment.

Mr. DINGELL. Now, Golden Rule Financial Corporation, did they distribute these dividends? And, if so, to whom did they distribute them?

Mr. WHELAN. Would you repeat the period of time you are talking about?

Mr. DINGELL. Did Golden Rule Financial Corporation distribute these dividends? And, if so, to whom did they distribute them?

Mr. WHELAN. Golden Rule Financial has a policy of paying dividends to its stockholders, and over the period that you talked about there probably were dividends paid to the stockholders.

Mr. DINGELL. In 1993, didn't Golden Rule Insurance Company pay $10 million in stockholder dividends to the parent corporation?

Mr. WHELAN. Yes, sir.

Mr. DINGELL. Now, what did Golden Rule Financial Corporation do with the $10 million?

Mr. WHELAN. The $10 million that came up in 1993, I believe there was a dividend paid in 1993. It was not the entire 10 million, to my recollection. The parent company has financing obligations. There was probably repayment up through dividends that would enable the parent company to service debt.

Mr. DINGELL. Since 1988, has Golden Rule Insurance Company paid any management fees to the parent corporation?

Mr. WHELAN. Since 1998?

Mr. DINGELL. No. It says 1988.

Mr. WHELAN. Since 1988? Yes, sir. There is a management agreement between the insurance company and the holding company, the holding company providing management services to the insurance company.

Mr. DINGELL. What was the total amount of these management fees?

Mr. WHELAN. I didn't come prepared with those, and I couldn't give them to you off the top of my head.

Mr. DINGELL. Last month, Teresa Rooney was named President and Chief Executive Officer of the Golden Rule Financial Corporation; isn't that so?

Mr. WHELAN. Yes, sir. I just told you that.

Mr. DINGELL. Now, who appointed Mrs. Rooney to this position?

Mr. WHELAN. Our Board of Directors elected her to that position at the recommendation of the Chairman.

Mr. DINGELL. What is the effect of this appointment on Golden Rule's overall operation?

Mr. WHELAN. The effect on the entire operation, meaning the enterprise of Golden Rule Financial and its subsidiaries, is that Teresa Rooney picks up the chief executive's role at the financial cor-

poration. I retain the chief executive's role at the insurance company. And the operations will continue to move forward.

Mr. DINGELL. Is Mr. Rooney a registered lobbyist pursuant to the Federal Regulation Lobbying Act?

Mr. WHELAN. I believe that he is, sir.

Mr. DINGELL. Is he a registered lobbyist for Golden Rule Insurance Company?

Mr. WHELAN. I believe so.

Mr. DINGELL. Beg your pardon?

Mr. WHELAN. I believe so.

Mr. DINGELL. Now, according to his filing, he is listed as an employee of Golden Rule Insurance Company. He doesn't check the box that he is reporting as an individual. Is that right?

Mr. WHELAN. Yes.

Mr. DINGELL. How much money did Mr. Rooney report spending on lobbying activities in the last 2 years—that is between July 1992 and July 1994?

Mr. WHELAN. Mr. Chairman, I am informed that the number is somewhere between $200,000 and $400,000. I do not know that independently, but I would be pleased to get it for you.

Mr. DINGELL. Now, your attorneys represented Golden Rule as a closely held family business, and they tended to characterize Golden Rule as a mom and pop operation. They indicated that they thought the committee's inquiry into this matter was the intrusive watch of Big Brother. Your company has assets over a billion dollars and premium revenues in something on the order of $800 million, does it not?

Mr. WHELAN. Yes, it does.

Mr. DINGELL. Now, let's talk about this business of minimum guaranteed loss ratios. Testimony earlier indicated that there are some problems with this proposal. Isn't it correct that this proposal would exempt insurance companies such as Golden Rule from a regulatory review of rates so long as it returned an arbitrary percentage of the premium dollars to consumers in benefits?

Mr. WHELAN. No, that is not it. That is not a correct characterization. The loss ratio guarantee issue is an effort on our part to assure that the policy holder gets a minimum return. That is something that doesn't occur today.

Now, the reason that we brought that concept to a number of States and have succeeded in getting States to adopt it as part of a law is that, in return for the ability to file and use the rates, the insurer agrees that if the experience doesn't meet a minimum that it will refund premium to the policyholders so that the reduced premium laid up next to the claims meets that minimum level.

Now, as part of that, we audit the performance. We report—we have an outside CPA firm review that and issue an opinion letter on it. That reporting goes in to the Department of Insurance. The records are open for inspection, and what we are guaranteeing——

Mr. DINGELL. Well, that is all very good, but I don't think it really relates to the question. You were asking that as long as you return 55 percent to your customers, that the State not intrude into the regulation of the business of the company. Isn't that what your request was to them?

Mr. WHELAN. No, that was not what our request was.

Mr. DINGELL. What was the request then?

Mr. WHELAN. Our request was for a loss ratio guarantee where we would guarantee the loss ratios that are filed initially in the product when the product is approved. The State sets out a standard that says, for an individual health product, this is the loss ratio that you must meet.

Mr. DINGELL. Fifty-five percent?

Mr. WHELAN. In a number of States it is 55 percent. Some States have 60 percent.

Now, the reality is for that 55 percent, it is not—it is a number that the National Association of Insurance Commissioners has developed in their model as the standard for individual health insurance. It is made up of a lower loss ratio in the first year, and the difference between the lower loss ratio in the first year and the rest of the premium is eaten up in the administrative expenses and the marketing cost to put the product on the books.

The first year in the health insurance business is a break-even year. It is not a big running away with lots of profits for the insurer.

The 55 percent represents an average over the lifetime of the product which incorporates that early period when you are putting the book of business together and people haven't started submitting claims and the later period when the claims are running up into the 70 percent level.

Mr. DINGELL. You don't sell your insurance on a 1-year basis, do you? You sell it on the assumption it is going to go on, that the sale is going to continue over a goodly period of time, do you not?

Mr. WHELAN. The reality is most of our customers hold the product only until they can find group insurance coverage.

Mr. DINGELL. Only what?

Mr. WHELAN. Only until they can find group insurance coverage.

Mr. DINGELL. How long is that?

Mr. WHELAN. It varies, but the lapse rate on the product is very high. Forty percent of it lapses off in the first year after issue.

Mr. DINGELL. What is the loss ratio of your company over the spectrum of its policies?

Mr. WHELAN. Over the spectrum of the policy, the business, as I said, will go on at a very low loss ratio as the business is being put on and before the claims start coming in. It is not uncommon that a first year loss ratio is in the 40 to 50 percent area. The loss ratios on the business after a year or 2 are in the 70 percent range. And it is also not uncommon to have loss ratios much above 70 percent, and there have been instances where loss ratios have been over 100 percent.

Mr. DINGELL. What is there in your proposal that would prevent insurance companies from lowballing premiums to get high market share?

Mr. WHELAN. Well, the problem with lowballing premiums—if I understand lowballing, and we have never tried it—you would price the product at a rate that is inadequate for the claim experience that you expect, for example, you are not charging them enough money. If that happens, you are going to wind up with a very high first year loss ratio.

The other phenomena in individual health insurance is you have a dramatic increase in the loss ratio between the first year and the second year, as much as a 50 percent increase between first year and second year. That is simply the people are coming on. They are starting to submit claims.

If you start with an inadequate premium and too high of a loss ratio, you are going to wind up with the need for very, very high rate increases simply to keep the book of business even and break even on it, no less make any money.

Now, if you do that, the people who are going to leave you when you give them those high rate increases are the healthy people because they have options. They can go apply somewhere else. They can do without the coverage. The people who will remain are the unhealthy, and the premium that you wind up charging will not be enough, so you will get into a cycle where you just keep on chasing yourself charging ever higher premiums.

We do not lowball. We do not advocate it. We do not think that it is a formula that can work.

Mr. DINGELL. Now, under your minimum guaranteed loss ratio proposal, what would prevent insurance companies from conducting their affairs so that the desired loss ratio is achieved or exceeded through bookkeeping mechanisms? What would prevent that?

Mr. WHELAN. Well, the proposal that we have supported and that has gone into the law requires that the company have the results audited by an outside firm. We have an outside CPA firm. The firm that does the audit for Golden Rule do this for us for every State and report to the State their testing of the reserves and the claim experience.

Mr. DINGELL. That would be done by some outside auditor?

Mr. WHELAN. That's right.

Mr. DINGELL. It would not be done by the Insurance Commissioner?

Mr. WHELAN. The Insurance Commission can come in and examine the books, and they do come in and do financial exams and conduct exams.

Mr. DINGELL. If that were to happen, refunds would never be made or would be, at best, minimal; isn't that so?

Mr. WHELAN. If what were to happen, sir?

Mr. DINGELL. If insurance companies were to keep their books and to game the system so that the desired loss ratio is achieved or exceeded and, thus, refunds are never made or are minimal.

Mr. WHELAN. Well, you could speculate on gaming the system, but the reality is it is very easy to come and check. The claim liability tail on individual health insurance is very short. When you are 6 months past the date of the liability, you are probably 90 percent paid on the liability. So it would be very easy to come out and look at the runout after 6 months and say how much have you paid on the incurrals that you say were there as of December 31? It is not something that you can hide and say I am going to stick away several million dollars in a reserve that is going to pay out over the next 5 years. It simply runs out quickly.

Mr. DINGELL. Let's take a look at this. Are there States in which a proposal like your minimum guaranteed loss ratio is in effect?

Mr. WHELAN. Yes, there are a number of States that have it in effect. Florida has it in effect. Arkansas has it in effect. I believe Connecticut has it in effect. And there are other States, and we have made refunds in a good number of States.

Mr. DINGELL. Have you made any refunds in those States under that kind of proposal?

Mr. WHELAN. Yes, we have. We have made refunds in each year, and we are making refunds for the year of 1993.

Mr. DINGELL. Would you make that information on the refunds that you have made in those States available to the committee, please?

Mr. WHELAN. We would be pleased to make that available.

Mr. DINGELL. The subcommittee is going to continue looking at the question of loss ratios and the technical aspects of this, including the underlying premises of computing loss ratios. But we will be having a number of additional questions for you, and I hope that you will respond, if you please.

Mr. WHELAN. We would be pleased to respond.

Mr. DINGELL. Gentlemen, we thank you for your presence today. The subcommittee stands adjourned.

[Whereupon, at 4:30 p.m., the subcommittee was adjourned.]

BOSTON PUBLIC LIBRARY
3 9999 05982 366 4

ISBN 0-16-046673-3

90000
9 780160 466731